

12003

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miners Hospital				d. STREET ADDRESS 172 W. Mechanic St.			
3. NAME OF DECEASED (Type or print) First LOUIS Middle AIRHART Last 				4. DATE OF DEATH Month Dec. Day 7 Year 19 56			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6-10-1892	
9. AGE (In years last birthday) 64 yrs.		IF UNDER 1 YEAR Months Days Hours Min. 		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer Construction Kelly-Spgf'd Co.		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME (work John Airhart)			
14. MOTHER'S MAIDEN NAME unknown				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) 218-07-9613			
16. SOCIAL SECURITY NO. 218-07-9613				17. INFORMANT Mrs. Edith Airhart, Frostburg, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia, bilateral DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) DUE TO (c) 							INTERVAL BETWEEN ONSET AND DEATH 5 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic Heart Disease							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. (IF EITHER, NOTIFY MEDICAL EXAMINER) XXXXXX				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) XXXXXX			
20c. TIME OF INJURY Month, Day, Year Hour a. m. XXX 19 19 p. m. XXX				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) XXX	
20f. (City or town) XXX				20g. (County) 		20h. (State) 	
21. I certify that I attended the deceased from Dec. 5 , 19 56 , to Dec. 7 , 19 56 , that I last saw the deceased alive on Dec. 7 , 19 56 , and that death occurred at 4:30AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Martin M. Rothstein</i>				ADDRESS (Street, city or town, state) 48 Broadway			
DATE SIGNED 12/8/56							
PHYSICIAN'S NAME (Type) Martin M. Rothstein M.D. Frostburg, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-9-56		22c. NAME OF CEMETERY OR CREMATORY Eckhart Cemetery		22d. LOCATION (City, town, or county) (State) Eckhart, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. R. Durst,				ADDRESS Frostburg, Md.		24a. REC'D BY REGISTRAR DATE 12-9-56	
				24b. REGISTRAR'S SIGNATURE <i>Mrs. Nancy N. Roe</i>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in only event within 72 hours after death.

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF ENTRY INTO STATE

DATE OF ENTRY INTO COUNTRY

DATE OF ENTRY INTO CITY

DATE OF ENTRY INTO DISTRICT

DATE OF ENTRY INTO TOWN

DATE OF ENTRY INTO VILLAGE

DATE OF ENTRY INTO PARISH

DATE OF ENTRY INTO CHURCH

BUREAU V. 3

DEC 14 1956

RECEIVED

Within corporate limits

DR. WEISMAN

11952

CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND, MD.		c. LENGTH OF STAY IN 1b 9 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL,		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND, MD. BEDFORD ROAD, RT. 3	
3. NAME OF DECEASED (Type or print) FANNIE V. AMBROSE		4. DATE OF DEATH Month 12 Day 25 Year 1956	
5. SEX FEMALE	6. COLOR OR RACE WHITE.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 7, 1884
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY U. S. A.	
13. FATHER'S NAME JACOB BURNS.		14. MOTHER'S MAIDEN NAME MARY GAVER.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT ME		Address MEMORIAL HOSPITAL CUMBERLAND, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL INFARCTION 391K DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 2600 (b) SLOW HEMORRHAGE OF BRAIN DUE TO (c) HYPERTENSION + ARTERIOSCLEROSIS PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) DIABETES OLD HEMORRHAGE OF BRAIN			INTERVAL BETWEEN ONSET AND DEATH 11 days 11 days 11 years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec 25, 1956 to Dec 25, 1956 , that I last saw the deceased alive on Dec 25, 1956 , and that death occurred at 8:15 P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Haversman		ADDRESS (Street, city or town, state) 596 KEENE ST CUMBERLAND, MARYLAND	
PHYSICIAN'S NAME (Type) DR. G. WEISMAN		DATE SIGNED 12/26/56	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	Dec. 28, 1956	Westcrest	Cumberland Md.
23. FUNERAL DIRECTOR'S SIGNATURE Louis Stein Inc.		24. REC'D BY REGISTRAR Dec. 27, 1956	
ADDRESS Cumb. Md		25. REGISTRAR'S SIGNATURE W.R. Frantz, M.D.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, the funeral director, TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 5

DEC 31 1957

RECEIVED

12004 CERTIFICATE OF DEATH

Reg. Dist. No.

9

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg				c. LENGTH OF STAY IN 1b 5 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miner's				d. STREET ADDRESS First Street			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last James H. Bennett				4. DATE OF DEATH Month Day Year December 5 1956			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7-24-1890	
9. AGE (In years last birthday) 66 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Celanese		11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Jobe Bennett				14. MOTHER'S MAIDEN NAME Ellen Lease			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes		16. SOCIAL SECURITY NO. W. W. #1 220-10-2646		17. INFORMANT Address Mrs. James H. Bennett, 29 First St., City			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Respiratory acidosis + alkalosis (alt.) DUE TO (c) Subular pneumonia - confluent LLL						INTERVAL BETWEEN ONSET AND DEATH 1 hr. 7d 10d.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary fibrosis + emphysema; Toxic myocarditis on f.c. & v. dis.						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Frostburg		20g. (County) Allegany		20h. (State) Md	
21. I certify that I attended the deceased from 11/27, 1956 , to 12/4, 1956 , that I last saw the deceased alive on 12/4, 1956 , and that death occurred at 6 A. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Frank T. Harratt		M.D. 26 Mechanic St.		ADDRESS (Street, city or town, state) Frostburg, Md		DATE SIGNED 12/7/56	
PHYSICIAN'S NAME (Type) FRANK T. HARRATT		22a. BURIAL CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 8, 1956		22c. NAME OF CEMETERY OR CREMATORY Frostburg Memorial	
22d. LOCATION (City, town, or county) Frostburg, Maryland		22e. (State) Md		23. FUNERAL DIRECTOR'S SIGNATURE Walter Funeral Home, Frostburg, Md.		ADDRESS 12-8-56	
24a. REC'D BY REGISTRAR Wm. Nancy H. De		24b. REGISTRAR'S SIGNATURE Wm. Nancy H. De		24c. DATE 12-8-56			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The funeral director, after this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. S.

DEC 14 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11933

DR. VAN ORMER

11953

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE WEST VIRGINIA b. COUNTY PENDLETON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ONEGO	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL-MEMORIAL & WARWICK AVES.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ZETTIE First C Middle BENNETT Last		4. DATE OF DEATH Month DECEMBER Day 3 Year 1956	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APRIL 15, 1887 69 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) WEST VIRGINIA
13. FATHER'S NAME ISAAC KISAMORE		14. MOTHER'S MAIDEN NAME MARY MALLOW	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT MEMORIAL HOSPITAL-CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage with left hemiplegia 260X DUE TO Conditions, if any, which gave rise to immediate cause (b) Myocardial Infarction, anterior lat., post 25 Sept 56 DUE TO lying cause lost. (c) Hypertensive Cardiovascular Disease ? Interval between onset and death 3 Dec 56		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) D. Diabetes Mellitus - 2 years.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 25 Sept , 19 56 , to 3 Dec , 19 56 , that I last saw the deceased alive on 3 Dec 56 , 19 56 , and that death occurred at 3:00 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) W. A. Van Ormer, M.D. DATE SIGNED 3 Dec 56			
ACTUAL SIGNATURE W. A. Van Ormer, M.D.			
PHYSICIAN'S NAME (Type) W. A. Van Ormer, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Dec. 6, 1956	22c. NAME OF CEMETERY OR CREMATORY Harmon Hills Cemetery	22d. LOCATION (City, town, or county) (State) Harmon Hills, Pendleton Co., W. Va.
23. FUNERAL DIRECTOR'S SIGNATURE Blaine Schaffer - Petersburg W. Va.		24a. REC'D BY REGISTRAR Dec 5, 1956	24b. REGISTRAR'S SIGNATURE W. R. Frank, M.D.

DEC 7 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12005 CERTIFICATE OF DEATH

11934

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miners Hospital		d. STREET ADDRESS 143 Wood St.	
3. NAME OF DECEASED (Type or print) First EARL Middle W. Last BLOUGH		4. DATE OF DEATH Month Dec. Day 4 Year 19 56	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-24-1902
9. AGE (In years last birthday) 54 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sales manager		10b. KIND OF BUSINESS OR INDUSTRY Green Chevrolet Co.	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Milton J. Blough		14. MOTHER'S MAIDEN NAME Laura E. Thomas	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 215-07-5093	
17. INFORMANT Mrs. Blanch Blough,		Address Frostburg, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 3 hrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec 4 , 19 56 , to Dec 4 , 19 56 , that I last saw the deceased alive on Dec 4 , 19 56 , and that death occurred at 3:18 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED WOM Lane M.D. Frostburg Md 12/5/56 PHYSICIAN'S NAME (Type) W O Mc Lane M D			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-7-56	
22c. NAME OF CEMETERY OR CREMATORY F'bg. Memorial Park		22d. LOCATION (City, town, or county) (State) Frostburg, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. R. Durst,		ADDRESS Frostburg, Md.	
24a. REC'D BY REGISTRAR DATE 12-7-56		24b. REGISTRAR'S SIGNATURE Miss Nancy N. As	

STATE OF MARYLAND
DEPARTMENT OF HEALTH - BALTIMORE 10
CERTIFICATE OF DEATH

RECEIVED
DEC 30 1956
BUREAU V. S.

12006

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg				c. LENGTH OF STAY IN 1b Lifetime			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 50 West College Avenue				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF Frederick W. Boettner (Type or print) First Middle Last				4. DATE OF DEATH Month December Day 9 Year 19 56			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 5, 1896		9. AGE (In years last birthday) yrs	F UNDER 1 YEAR Months	IF UNDER 24 HRS Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Frostburg, Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Henry J. Boettner				14. MOTHER'S MAIDEN NAME Christian Wink			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes World #1		16. SOCIAL SECURITY NO 213-05-7098		17. INFORMANT Mrs. Frederick Boettner Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Carcinoma DUE TO Carcinoma right kidney Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Introspective Heart disease						INTERVAL BETWEEN ONSET AND DEATH 7-8 months 7-8 months	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from September 1952 to December 7, 1956 that I last saw the deceased alive on December 6, 1956 , and that death occurred at 5:00 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 48 Broadway, Frostburg, Md. DATE SIGNED 12/10/56 ACTUAL SIGNATURE Hilda Jane Walters M.D. PHYSICIAN'S NAME (Type) Hilda Jane Walters, M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-11-56		22c. NAME OF CEMETERY OR CREMATORY Frostburg Memorial		22d. LOCATION (City, town, or county) (State) Frostburg, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE P. H. Mattingly, Frostburg, Md. ADDRESS				24a. REC'D BY REGISTRAR DATE 12-11-56		24b. REGISTRAR'S SIGNATURE Mrs. Mary N. Lee	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, of the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

DEPT. OF JUSTICE
BUREAU V. S.

DEC 17 1954

RECEIVED
DEC 17 1954

12007 CERTIFICATE OF DEATH

Reg. Dist. No.

9

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Savage,	
c. LENGTH OF STAY IN 1b 21 Days		d. STREET ADDRESS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miners Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Bessie Regina Bridges		4. DATE OF DEATH Month December Day 29 Year 19 56	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept 6, 1888
9. AGE (In years last birthday) yrs 68		IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Presser		10b. KIND OF BUSINESS OR INDUSTRY Dry Cleaning	
11. BIRTHPLACE (State or foreign country) Bedford Valley, Penn.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Benton Bridges		14. MOTHER'S MAIDEN NAME Phoebe Ann Miller	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 291-03-2624	
17. INFORMANT Miss Grace Bridges, Akron, Ohio		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARCINOMA OF PANCREAS 1956 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 10 mos?
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from OCT. 6, 1956 to DEC. 29, 1956 , that I last saw the deceased alive on DEC. 29, 1956 , and that death occurred at 2:10 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 48 BROADWAY DATE SIGNED 1/2/57			
ACTUAL SIGNATURE MARTIN M. ROTHSTEIN M.D.			
PHYSICIAN'S NAME (Type) MARTIN M. ROTHSTEIN M.D. FROSTBURG, MD.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Jan 2, 1957	22c. NAME OF CEMETERY OR CREMATORY St. Patrick's Cath Cem	22d. LOCATION (City, town, or county) (State) Mt. Savage, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland		24a. REC'D BY REGISTRAR DATE 1-2-57	
		24b. REGISTRAR'S SIGNATURE Nancy H. Roe	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

EVANS, A. S.

JAN 2

RECORDED

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

12021

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Md. b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Vale Summit		c. LENGTH OF STAY IN 1b 64 years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Mt. about 1.5 miles south of Rt. 55		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland	
3. NAME OF DECEASED (Type or print) First Middle Last Harry McGill Brotemarkle		4. DATE OF DEATH Month Day Year Dec. 13 19 56	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 15-1892
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shauffeur Foreman		10b. KIND OF BUSINESS OR INDUSTRY State Rd. Comm. Cumberland, Md.	
13. FATHER'S NAME Michael Brotemarkle		14. MOTHER'S MAIDEN NAME Louisa Simons	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 2 12-38-5429	
17. INFORMANT (wife) Maud B. Brotemarkle, Cumberland, Md.		Address	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary sclerosis (marked)		INTERVAL BETWEEN ONSET AND DEATH sudden	
DUO TO 410.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b) Myocardial infarction	
DUO TO Cardiac hypertrophy		(c) ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE H. V. Deming M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) H. V. Deming M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Dec. 14-1956	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/16/56	
22c. NAME OF CEMETERY OR CREMATORY Hilcrest Burial Park		22d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland		24a. REC'D BY REGISTRAR Dec. 16, 1956	
		24b. REGISTRAR'S SIGNATURE Wm. Maurice H. Rose	

TO DEPUTY MEDICAL EXAMINER: This certificate should be examined within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

DEC 9 1956

RECEIVED

11954 CERTIFICATE OF DEATH

11938

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>W. Va.</u> b. COUNTY <u>Lewis</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Walkersville</u>	
c. LENGTH OF STAY IN 1b <u>6 mos.</u>		d. STREET ADDRESS <u>225 Glenn St.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>225 Glenn St.</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>HERNOLD</u> Middle <u>WILL</u> Last <u>CHAPMAN</u>		4. DATE OF DEATH Month <u>Dec.</u> Day <u>3</u> Year <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 18, 1885</u>
9. AGE (In years last birthday) <u>71</u> yrs		10. IF UNDER 1 YEAR: IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>W. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>David Farinash</u>		14. MOTHER'S MAIDEN NAME <u>Alice Shannon</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs. Lena Crook</u>		Address <u>225 Glenn St. Cumberland, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the</u> DUE TO <u>Carcinoma large bowel</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <u>Carcinoma large bowel</u> DUE TO (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 mos.</u> <u>6 mos.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>3/7/55</u> , 19 <u>55</u> , to <u>12/3/56</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>2/6/55</u> , 19 <u>55</u> , and that death occurred at <u>M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Cumberland, Md.</u>			
ACTUAL SIGNATURE <u>B. J. Williams</u>		DATE SIGNED <u>12/7/56</u>	
PHYSICIAN'S NAME (Type) <u>B. J. Williams, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Dec. 5, 1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>McCutcheon Chapel Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Ireland, W. Va.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles L. George, Cumberland, Md.</u>		24. REC'D BY REGISTRAR <u>Dec. 5, 1956</u>	
		24b. REGISTRAR'S SIGNATURE <u>W. L. Hantz, M.D.</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

NO. 10

1910

11939

12022

CERTIFICATE OF DEATH

Reg. Dist. No. 6

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institutional Residence before admission) a. STATE <u>Id.</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Luke</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Luke</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Cronwell St.</u>		d. STREET ADDRESS <u>Cronwell St</u>	
3. NAME OF DECEASED (Type or print) First <u>Eliza</u> Middle <u>May</u> Last <u>Cox</u>		4. DATE OF DEATH Month <u>Dec.</u> Day <u>9</u> Year <u>19 56</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>17 Jan 1880</u>
9. AGE (In years less birthday) yrs <u>76</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles A. Kight</u>		14. MOTHER'S MAIDEN NAME <u>Eliza Ann Gilbert</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO	
17. INFORMANT <u>John Cox</u>		Address <u>Luke, Id.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Degeneration Not Specified as Rheumatic</u> <u>422.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>3.0</u> INTERVAL BETWEEN ONSET AND DEATH <u>2 Years</u>			
20a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II column 18) <u>Fall on step, contusion of left hip - no fracture on Nov. 25, 1956</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>10</u> p. m. <u>Nov. 25 1956</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Luke Allegany Md</u>	
21. I certify that I attended the deceased from <u>Nov. 25, 1956</u> , to <u>Dec. 9, 1956</u> , that I last saw the deceased alive on <u>Dec. 9, 1956</u> , and that death occurred at <u>8:45 P. M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Piedmont, W. Va.</u> DATE SIGNED <u>Dec. 12, 1956</u>			
ACTUAL SIGNATURE <u>Paul B. Wilson</u> M.D.		PHYSICIAN'S NAME (Type) <u>Piedmont, W. Va.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/12/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Hanner Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Harpers Ferry W. Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>E. J. Boal</u>		ADDRESS <u>Westernport, Md.</u>	
24a. REC'D BY REGISTRAR <u>12-12-56</u>		24b. REGISTRAR'S SIGNATURE <u>Miss Jean C. Kelly</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

W. A. RYAN

EC 17 1956

W. A. RYAN

Within corporate limits

11955

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND			c. LENGTH OF STAY IN 1b 7 DAYS		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL, MEMORIAL & WARWICK AVES.,			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PAW PAW, W. VA., Rural ×		
			d. STREET ADDRESS R.F.D. #1		
3. NAME OF DECEASED (Type or print) First JOHN Middle R. Last CRABTREE			4. DATE OF DEATH Month DEC. Day 19 Year 1956		
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH JULY 4, 1873		9. AGE (In years last birthday) 83 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Orchard Worker		10b. KIND OF BUSINESS OR INDUSTRY Orchard Co.		11. BIRTHPLACE (State or foreign country) XXXXX Allegany County, Maryland	
12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME MICHAEL CRABTREE			14. MOTHER'S MAIDEN NAME EDWINA XXXX TWIGG		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Memorial Hospital	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis (c) Generalized arteriosclerosis					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
		20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from 12/12, 1956 , to 12/19, 1956 , that I last saw the deceased alive on 12/19, 1956 , and that death occurred at 1:50 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 128 Elm St., Cumberburg, Md. DATE SIGNED 12/19/56					
ACTUAL SIGNATURE George M. Simons M.D. George M. Simons, M.D.					
PHYSICIAN'S NAME (Type) GEORGE SIMONS					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 22, 1956		22c. NAME OF CEMETERY OR CREMATORY Green Ridge Cemetery	
				22d. LOCATION (City, town, or county) (State) Green Ridge, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Park's Funeral Home, Paw Paw, West Virginia.			24. REC'D BY REGISTRAR 21, 1956		
			24b. REGISTRAR'S SIGNATURE A.R. Frantz, M.D.		

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

DEC 20 1966

RECEIVED

11941

11955

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 3/1/56	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Borden Yard, Frostburg, Md.	
		d. STREET ADDRESS (Borden Yard)	
3. NAME OF DECEASED (Type or print) First Elizabeth Middle B. Last Craig		4. DATE OF DEATH Month December Day 20 , Year 1956	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/ /1869
9. AGE (In years last birthday) yrs 87		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - School Teacher - Teaching		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) U. S. A.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME William M. Browne		14. MOTHER'S MAIDEN NAME Elizabeth Borland	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. No	
17. INFORMANT P.O. Box 599		Address Cumberland, Md.	
Allegany County Infirmary Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Sclerosis 420.1 DUE TO Chronic Hypertension Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral Arteriosclerosis (c) Chronic Hepatitis			INTERVAL BETWEEN ONSET AND DEATH 2 weeks
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3/1/56 , 19___, to 12/20/56 , 19___, that I last saw the deceased alive on 12/20/56 , 19___, and that death occurred at 8:55 A. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE James E. McLean M.D.		ADDRESS (Street, city or town, state) 49 Greene St. DATE SIGNED 12/20/56	
PHYSICIAN'S NAME (Type) Dr. James E. McLean		Cumberland, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Dec. 22, 1956	22c. NAME OF CEMETERY OR CREMATORY Frostburg Memorial Park	22d. LOCATION (City, town, or county) (State) Frostburg, Maryland.
23. FUNERAL DIRECTOR'S SIGNATURE Durst Funeral Home, Frostburg, Maryland.		24. REC'D BY REGISTRAR Dec. 21, 1956 24b. REGISTRAR'S SIGNATURE W. R. Frank M.D.	

RECEIVED

RECEIVED

12008

CERTIFICATE OF DEATH

11942

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frostburg</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frostburg</u>			
c. LENGTH OF STAY IN TB <u>2 Days</u>				d. STREET ADDRESS <u>II Standish Street</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Minor's Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>James Taylor Crump</u>				4. DATE OF DEATH Month Day Year <u>Dec. 12 1956</u>			
5 SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-15-1889</u>	9. AGE (In years last birthday) <u>76 1/2</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Accountant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Alleg. Ballistics</u>		11. BIRTHPLACE (State or foreign country) <u>Frostburg</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>James E. Crump</u>				14. MOTHER'S MAIDEN NAME <u>Mary Jane Taylor</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>163-05-5179</u>			
				17. INFORMANT <u>Ralph F. Crump, (Son)</u> Address <u>Point Pleasant W. Va.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>153x Cardiac dilatation</u> DUE TO (b) <u>Pulmonary metastasis</u> DUE TO (c) <u>Carcinoma of caecum Primary</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>2 days</u> <u>2 months</u> <u>6 months</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>12/7/1956</u> to <u>12/12/1956</u> , that I last saw the deceased alive on <u>12/12/1956</u> , and that death occurred at <u>1:30 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>W.E. Lattens</u>				ADDRESS (Street, city or town, state) <u>167 E. Main St Frostburg, Md.</u>			
PHYSICIAN'S NAME (Type) <u>W.E. Lattens M.D.</u>				DATE SIGNED <u>12/15/56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-15-1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Frostburg Mem. Park</u>		22d. LOCATION (City, town, or county) (State) <u>Frostburg Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Paul H. Mattingly, Frostburg, Md.</u>				24a. REC'D BY REGISTRAR <u>DATE 12-15-56</u>			
				24b. REGISTRAR'S SIGNATURE <u>Miss Nancy H. Poe</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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DEC 10 1956

BUREAU V. E.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11943

11957

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 3 1/2 mo.		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cumberland	
d. NAME OF HOSPITAL (if not in hospital, give street address) OR INSTITUTION 1508 Fredrick, St			d. STREET ADDRESS 1508 Fredrick, St.		e. 15 RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Annie Middle Ethel Last Day			4. DATE OF DEATH Dec. 11, 19 56		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 26, 1876	9. AGE (In years last birthday) 79 yrs	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper at Home		10b. KIND OF BUSINESS OR INDUSTRY at Home		11. BIRTHPLACE (State or foreign country) Virginia	
13. FATHER'S NAME Francis M. Kidwell			14. MOTHER'S MAIDEN NAME Isabelle McDonald		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. none		17. INFORMANT Address Lawrence G. Day Cumberland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO Hypertension Coronary Artery Disease - ventricular fibrillation Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension Coronary Artery Disease - ventricular fibrillation (c) Hypertension Coronary Artery Disease - ventricular fibrillation					INTERVAL BETWEEN ONSET AND DEATH immediate
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from 5/1/56 , 19 to 12/4/56 , 19, that I last saw the deceased alive on 12/4/56 , 19, and that death occurred at 7/11 M, from the causes and on the date stated above. ADDRESS (Street, city or town—state) Cumberland Md DATE SIGNED 12/17/56					
ACTUAL SIGNATURE R. J. Williams, M.D.					
PHYSICIAN'S NAME (Type) R. J. Williams, M.D.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12/14/56	22c. NAME OF CEMETERY OR CREMATORY Fort Ashby Cemetery	22d. LOCATION (City, town, or county) (State) Fort Ashby, W. Va.		
23. FUNERAL DIRECTOR'S SIGNATURE H. Lee Silcox - Cumberland, Md.			24. REC'D BY REGISTRAR Dec. 14, 1956 24b. REGISTRAR'S SIGNATURE W. L. Frank, M.D.		

BUREAU V. E.

DEC 10

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12023

CERTIFICATE OF DEATH

Reg. Dist. No. 8

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lonaconing				c. LENGTH OF STAY IN 1b 74 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Jackson Street				e. STREET ADDRESS Jackson Street			
3. NAME OF DECEASED (Type or print) First BERTHA Middle B. Last DICK				4. DATE OF DEATH Month 12/15.1956 Day 19 Year 19			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/19/1882	9. AGE (In years last birthday) 74 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Lonaconing, MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James W. Bishop				14. MOTHER'S MAIDEN NAME Matilda Sperry			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT James Dick, Lonaconing, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of sigmoid & metastases 153x DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH 6 mos.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July</u> , 19 <u>56</u> , to <u>Dec.</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Dec. 18</u> , 19 <u>56</u> , and that death occurred at <u>2 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Lonaconing Md</u> DATE SIGNED <u>12.17.56</u> ACTUAL SIGNATURE <u>Leslie R. Miles, Jr., M.D.</u> PHYSICIAN'S NAME (Type) <u>Leslie R. Miles, Jr., M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/18/1956		22c. NAME OF CEMETERY OR CREMATORY Oak Hill Cemetery		22d. LOCATION (City, town, or county) (State) Lonaconing, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE George Eichhorn, Lonaconing, MD.				24a. REC'D BY REGISTRAR DATE <u>1/19/56</u>		24b. REGISTRAR'S SIGNATURE <u>Janette M. Pool</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. E.

DEC 24 1910



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11958

CERTIFICATE OF DEATH

Reg. Dist. No.

11946

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE PENNSYLVANIA b. COUNTY Bedford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HYNDMAN	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.		d. STREET ADDRESS CHURCH ST.	

3. NAME OF DECEASED (Type or print) ELLIOTT		4. DATE OF DEATH Month DECEMBER Day 22 Year 1956	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCTOBER 28, 1879
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MINER		10b. KIND OF BUSINESS OR INDUSTRY MINING	11. BIRTHPLACE (State or foreign country) PENNA
13. FATHER'S NAME JOHN DIVELBISS		14. MOTHER'S MAIDEN NAME MARGARET KILES	

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) NO		16. SOCIAL SECURITY NO. 162-12-4145	17. INFORMANT Mrs. Nora Dwelbiss Hyndman, Pa.
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18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cancer Descending Colon DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 1 1/2 years	
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
--	--

20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Nov 1, 1955 to Dec 22, 1956 , that I last saw the deceased alive on 12-22, 1956 , and that death occurred at 12:25 PM , from the causes and on the date stated above.	
ACTUAL SIGNATURE John K. Topper	DATE SIGNED 12.22.56
PHYSICIAN'S NAME (Type) JOHN A. TOPPER	

22a. BURIAL, CREMATION, REMOVAL (Specify) Buried	22b. DATE THEREOF Dec. 26, 1956	22c. NAME OF CEMETERY OR CREMATORY Hyndman Cemetery	22d. LOCATION (City, town, or county) (State) Hyndman Pa
23. FUNERAL DIRECTOR'S SIGNATURE Harvey H. Lagler		24a. REC'D BY REGISTRAR Dec. 24, 1956	24b. REGISTRAR'S SIGNATURE W. K. Frantz, M.D.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

8 APR 1964

PLATE 1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11959 CERTIFICATE OF DEATH

11947

Reg. Dist. No.

1 PLACE OF DEATH a COUNTY <u>Allegheny</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a STATE <u>Penn.</u> b COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Sacred Heart</u>		d. STREET ADDRESS <u>325 1st St. S.E.</u>	
3 NAME OF DECEASED (Type or print) <u>Bernard Henry</u> First <u>Doll</u> Middle <u>Lost</u>		4. DATE OF DEATH <u>Dec. 30</u> Month <u>19/56</u> Year <u>19</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 11, 1886</u>
9. AGE (In years lost birthday) <u>70</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Tin Plate Worker.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Tin Mill</u>	11. BIRTHPLACE (State or foreign country) <u>Perryville, Mo.</u>
13. FATHER'S NAME <u>Martin Doll</u>		14. MOTHER'S MAIDEN NAME <u>Walburga --- (Unknown)</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Miss Mary Doll, Winifred Rd. Cumberland, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Left Ventricular Failure</u> <u>420.1</u> DUE TO <u>Severe Myocardial Fibrosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Severe Myocardial Fibrosis</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>Seconds</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Coronary Arteriosclerosis; Super-pubic cystotomy, Uremia</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>12-2-56</u> , 19 <u>56</u> , to <u>12-30-56</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>12-29-56</u> , 19 <u>56</u> , and that death occurred at <u>A.B.</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>50 Pershing St., Cumberland, Md.</u> DATE SIGNED <u>12-31-56</u>			
ACTUAL SIGNATURE <u>Samuel E. Jacobson</u> M.D.		PHYSICIAN'S NAME (Type) <u>Samuel E. Jacobson, M.D., A.C.P.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	22b. DATE THEREOF <u>Jan. 2, 1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Patrick's Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Cumberland, Md.</u>
23 FUNERAL DIRECTOR'S SIGNATURE <u>Charles F. George, Cumberland, Md.</u>		24a. REC'D BY REGISTRAR <u>Dec. 31, 1956</u>	
		24b. REGISTRAR'S SIGNATURE <u>W.R. Frank, M.D.</u>	

1957

12

DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11948

CERTIFICATE OF DEATH

Reg. Dist. No.

4

DR. BALLIN		11960		Reg. Dist. No. 4	
1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND, 1		c. LENGTH OF STAY IN 1b 1 DAY		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL-MEMORIAL & WARWICK AVE.		d. STREET ADDRESS 802 MEMORIAL AVE.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First HAMPTON Middle PAUL Last DRIVER		4. DATE OF DEATH Month DECEMBER Day 1, Year 1956			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 1 1890	9. AGE (In years last birthday) 66 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Car Inspector		10b. KIND OF BUSINESS OR INDUSTRY B&O Railroad		11. BIRTHPLACE (State or foreign country) VIRGINIA	
13. FATHER'S NAME J. A. DRIVER		14. MOTHER'S MAIDEN NAME BETTY REEVES			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 705-09-6698		17. INFORMANT Address MEMORIAL HOSPITAL, CUMBERLAND, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Heart Disease 410.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					INTERVAL BETWEEN ONSET AND DEATH 3 years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11-30 1956, to 12-1 1956, that I last saw the deceased alive on 12-1 1956, and that death occurred at 5:15 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Ralph W. Ballin, M.D. 62 Greene St. Cumberland, Md. 12-3-56					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/4/56		22c. NAME OF CEMETERY OR CREMATORY Hillcrest Cemetery	
23. FUNERAL DIRECTOR'S SIGNATURE H. Lee Silcox		ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR DATE 4, 1956	
				24b. REGISTRAR'S SIGNATURE Walter R. Frantz, M.D.	

MEDICAL CERTIFICATION

ROBERT V. S.

DEC 3

RECEIVED

Outside of
the limits

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled in by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use of the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										11949	
12024										CERTIFICATE OF DEATH	
Reg. Dist. No. 4											
1. PLACE OF DEATH a. COUNTY Allegany MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Allegany						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) near Cumberland, rural					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) near Cumberland, rural						
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eastman road, R.F.D. #2					d. STREET ADDRESS Eastman road, R.F.D. #2					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) EGBERT EARL DUVALL					4. DATE OF DEATH December 13 19 56						
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 1, 1898 58 yrs.		9. AGE (In years last birthday) 58 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Conductor					10b. KIND OF BUSINESS OR INDUSTRY B&O Railroad					11. BIRTHPLACE (State or foreign country) Fairfax, Virginia	
12. CITIZEN OF WHAT COUNTRY? U S A											
13. FATHER'S NAME WILLIAM DUVAL					14. MOTHER'S MAIDEN NAME HENRIETTA STOUT						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No					16. SOCIAL SECURITY NO. 705-07-9722		17. INFORMANT Mrs. Lena Duvall, Eastman Road, Cumberland, Maryland				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma Stomach with metastasis 151X DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. (b) To liver and abdominal wall DUE TO (c) Terminal Cachexia										INTERVAL BETWEEN ONSET AND DEATH Approx 4 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from August , 1956, to Dec 13 , 1956, that I last saw the deceased alive on Dec 4 , 1956, and that death occurred at M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Cumberland Md. DATE SIGNED Dec 13 1956 ACTUAL SIGNATURE W M Fafer Jr M.D. Cumberland Md. PHYSICIAN'S NAME (Type) W. M. Fafer, Jr. M.D. 5 Washington St. Cumberland, Md.											
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial			22b. DATE THEREOF 12/15/56		22c. NAME OF CEMETERY OR CREMATORY Mt. Tabor Meth. Cemetery Spring Gap Maryland			22d. LOCATION (City, town, or county) (State)			
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland					24a. REC'D BY REGISTRAR Dec 15, 1956		24b. REGISTRAR'S SIGNATURE W R. Frank M.D.				

RECEIVED

DEC 10 1956

BUREAU V. 3

Within corporate limits.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11950

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11961

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Md. b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 3 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 217 Union St.				d. STREET ADDRESS 214 Harrison St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Lester Middle H. Last Emery				4. DATE OF DEATH Month Dec. Day 13 Year 19 56			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH Oct. 22-1906		9. AGE (In years last birthday) 50 yrs.	IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrician		10b. KIND OF BUSINESS OR INDUSTRY Potomac Edison		11. BIRTHPLACE (State or foreign country) New Creek, W. Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Emery				14. MOTHER'S MAIDEN NAME Hannah Birley			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 214-10-5326		17. INFORMANT Susie Lee Yeider, Cumberland, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Coronary sclerosis with Angina syndrome -1 month Conditions, if any, which gave rise to immediate cause (b) (c) DUE TO (a), stating the underlying cause last. 							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE H. V. Deming M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) H. V. Deming M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Dec. 13-1956			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		Dec. 16, 1956		Rose Hill Cem.		Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Louis Stein, Inc.				ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR Dec. 16, 1956	
				24b. REGISTRAR'S SIGNATURE W. L. Hantz, M.D.			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

DEC 10 1966

RECEIVED

11962

CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. LENGTH OF STAY IN 1b <u>North Cumberland, Md.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Sacred Heart Hospital</u>		d. STREET ADDRESS <u>Rt. 5, Box #93</u>	
3. NAME OF DECEASED (Type or print) First <u>Voso</u> Middle <u>Eror</u> Last <u>Eror</u>		4. DATE OF DEATH Month <u>December</u> Day <u>11</u> Year <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar. 21, 1885</u>
9. AGE (In years last birthday) <u>71</u> yrs		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Silk Mill</u>	
11. BIRTHPLACE (State or foreign country) <u>Yugoslavia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Steve Eror</u> XXXXXX		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO <u>217-10-7781</u>	
17. INFORMANT <u>Donna Eror</u>		Address <u>Cumberland, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Acute posterior wall Myocardial Infarction</u> (c) <u>Hypertensive and arteriosclerotic Heart Disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u> <u>2 weeks</u> <u>5 weeks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Obesity</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>12/13, 1956</u> to <u>12/14, 1956</u> , that I last saw the deceased alive on <u>12/14, 1956</u> , and that death occurred at <u>4 P. M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>A. G. Weisman</u> M.D.		ADDRESS (Street, city or town, state) <u>59 GREENE ST</u> DATE SIGNED <u>12/17/56</u>	
PHYSICIAN'S NAME (Type) <u>S. G. WEISMAN</u> M.D.		<u>Cumberland, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12/17/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Cumberland, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. Lee Silcox</u>		24. REGISTRAR'S SIGNATURE <u>W. R. Frank, M.D.</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1, 2, 3, and 4 should be filed with the funeral director. After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

DEC 10 1956

RECEIVED

11963 CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 6/4/56	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 739 Washington St.	
3. NAME OF DECEASED (Type or print) First Frank Middle Leonard Last Fisher		4. DATE OF DEATH Month December Day 30 Year 1956	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/10/1863
9. AGE (In years last birthday) 93 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Theatre Owner		10b. KIND OF BUSINESS OR INDUSTRY Theatre	
11. BIRTHPLACE (State or foreign country) Emmellville, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Conrad Fisher		14. MOTHER'S MAIDEN NAME Margaret Luft	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) None	
17. INFORMANT P.O. Box 599		Address Cumberland, Md.	
18. CAUSE OF DEATH {Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Primary Hypostasis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Chronic Myocarditis (c) Cerebral Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 24 hrs ? ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Nephritis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6/4/56 , 19__ to 12/30/56 , 19__, that I last saw the deceased alive on 12/30/56 , 19__, and that death occurred at 1:40A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE James E. McLean M.D.		ADDRESS (Street, city or town, state) 49 Greene St. DATE SIGNED 12/30/56	
PHYSICIAN'S NAME (Type) Dr. James E. McLean		Cumberland, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1/1/57	22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery	22d. LOCATION (City, town, or county) (State) Cumberland, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George		ADDRESS Cumberland, Md.	
24. REC'D BY REGISTRAR 31, 1956		24b. REGISTRAR'S SIGNATURE W. R. Frantz, M.D.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 14 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

1967

RECEIVED

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 4

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of the death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY ALLEGANY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND c. LENGTH OF STAY IN 1b 27 DAYS d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL, MEMORIAL & WARRICK AVES.,		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE WEST VIRGINIA b. COUNTY HARDY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MOOREFIELD d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First LOTTIE Middle L. Last FRIDDLE		4. DATE OF DEATH Month DECEMBER Day 29 Year 1956	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 4, 1885 9. AGE (In years last birthday) 71 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) WEST VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME MORTON BLANTON		14. MOTHER'S MAIDEN NAME NANNIE EANS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT MEMORIAL HOSPITAL,		Address CUMBERLAND, MARYLAND	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL FAILURE DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 90.30 (b) ARTERIOSCLEROTIC -BEXR CARDIO VASCULAR DISEASE DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) OBLIQUE FRACTURE RIGHT FEMUR			INTERVAL BETWEEN ONSET AND DEATH GRADUAL ?
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) UNSTEADY WHEN WALKING IN HOME, STUMBLED AND FELL TO FLOOR	
20c. TIME OF INJURY Month, Day, Year Hour 8 a. m. p. m. DEC 1, 1956	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	20f. (City or town) (County) (State) MOOREFIELD HARDY W. VA.
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE H. V. Deming M.D.		DATE SIGNED DEC 29 - 1956	
EXAMINER'S NAME (Type) H. V. DEMING, MD.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF DEC 31, 1956	22c. NAME OF CEMETERY OR CREMATORY OLIVET CEMETERY	22d. LOCATION (City, town, or county) (State) MOOREFIELD W. VA.
23. FUNERAL DIRECTOR'S SIGNATURE P. C. Shumaker & Son		24a. REC'D BY REGISTRAR DEC 29, 1956	24b. REGISTRAR'S SIGNATURE W. R. Pearty, M.D.

RECEIVED

U. S. A.

11965

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 45 MINUTES	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WAR MEMORIAL & WARWICK AVES			d. STREET ADDRESS 927 GLENWOOD STREET		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) FLORIETTA			4. DATE OF DEATH Month DECEMBER Day 3 Year 1956		
5. SEX FEMALE	6. COLOR OR RACE COLORED	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH MAY 18, 1897		9. AGE (In years last birthday) 56 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) FAIRMONT, W. VA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME CHARLES FREEMAN			14. MOTHER'S MAIDEN NAME DORA WATSON		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	17. INFORMANT Address Mrs. Virgil Carter, Washington, D.C.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Failure 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (b) Acute myocardial Infarction DUE TO (c) Hypertensive Heart Disease					INTERVAL BETWEEN ONSET AND DEATH 1 1/2 hours 4 days 10 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED [Enter nature of injury in Part I or Part II at item 18.]			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from 1952 to Dec 3, 1956 , that I last saw the deceased alive on Dec 3, 1956 , and that death occurred at 11:05 AM , from the causes and on the date stated above.					
ACTUAL SIGNATURE SAVILLE		ADDRESS (Street, city or town, state) 59 Greene St		DATE SIGNED 12/4/56	
PHYSICIAN'S NAME (Type) SAMUEL G. WEISMAN		Cumberland, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12/6/56	22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery	22d. LOCATION (City, town, or county) (State) Cumberland, Maryland		
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland		ADDRESS		24a. REC'D BY REGISTRAR Dec 5, 1956	24b. REGISTRAR'S SIGNATURE W. K. Bank, M.D.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUNTING V. S.

10 - 1

W. A. BUNTING

12009

CERTIFICATE OF DEATH

Reg. Dist. No.

9

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 280 E. Main St.				d. STREET ADDRESS 280 E. Main St.			
3. NAME OF DECEASED (Type or print) First ALICE Middle L. Last GOETZ				4. DATE OF DEATH Month Dec. Day 17 Year 1956			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-27-1871	9. AGE (In years last birthday) 85 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Months Days Hours Min.	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housework		10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Porter				14. MOTHER'S MAIDEN NAME Mary Carruthers			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO none		17. INFORMANT Address Mrs. Mary Hugglestone, Frostburg, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial insufficiency 15X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension DUE TO (c) Coronary sclerosis						INTERVAL BETWEEN ONSET AND DEATH 6 mo Several years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 19 56 , to Dec 17 , 19 56 , that I last saw the deceased alive on Dec 5 , 19 56 , and that death occurred at 12:30 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE W. M. Lane M.D.				ADDRESS (Street, city or town, state) Frostburg Md		DATE SIGNED Dec 18 1956	
PHYSICIAN'S NAME (Type) W. M. Lane							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-19-56		22c. NAME OF CEMETERY OR CREMATORY St. George's Cemetery		22d. LOCATION (City, town, or county) (State) Mt. Savage, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. R. Durst,				ADDRESS Frostburg, Md.		24a. REC'D BY REGISTRAR DATE 12-19-56	
				24b. REGISTRAR'S SIGNATURE Mrs. Nancy N. Rose			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital, or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

U.S. AIR FORCE

1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

VINCEY/06! MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11956

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY (Allegany) (MARYLAND)		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Md. b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Keyser Danville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Danville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) D.P.A. POTOMAC/NAT'L HOSPITAL		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First Middle Last Walter Bradley Gordon		4. DATE OF DEATH Month Day Year Dec. 20 19 56	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 25-1956
9. AGE (In years last birthday) 0 yrs.		10. IF UNDER 1 YEAR Months 4 Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Cumberland, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Forrest Gordon		14. MOTHER'S MAIDEN NAME Phyllis Sturtz	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. ADDRESS (mother) Mrs. F. Gordon, Danville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxiation due to 1.0 DUE TO Aspiration of stomach contents. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Allegany	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE H.V. Deming M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) H.V. Deming M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Dec. 20-1956	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 22-1956	
22c. NAME OF CEMETERY OR CREMATORY Waxler Cemetery		22d. LOCATION (City, town, or county) (State) Allegany Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Rogers Funeral Home, Keyser, W.Va.		24a. REC'D BY REGISTRAR DATE 12-26-56	
24b. REGISTRAR'S SIGNATURE Jenn C Kelly			

2060274XV6

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pages 5 may be retained for your file. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

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011 111111

DR. BALLIN

11966

CERTIFICATE OF DEATH

Reg. Dist. No.

4

1 PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 13 DAYS	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		d. STREET ADDRESS 825 VIRGINIA AVENUE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL-MEMORIAL&WARWICK AVES.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First RAYMOND Middle J Last GRABENSTEIN		4. DATE OF DEATH Month DECEMBER Day 2 Year 1956	
5 SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 30 1923
9. AGE (In years last birthday) 33 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) General laborer		10b. KIND OF BUSINESS OR INDUSTRY Own Business	11. BIRTHPLACE (State or foreign country) MARYLAND Cumberland
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME JAMES GRABENSTEIN	
14. MOTHER'S MAIDEN NAME FRANCES BOCH		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT Address MEMORIAL HOSPITAL, CUMBERLAND, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lymphosarcoma DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) Cholelithiasis			INTERVAL BETWEEN ONSET AND DEATH 10 mos unknown
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 11-19 , 1956, to 12-2 , 1956, that I last saw the deceased alive on 12-2 , 1956, and that death occurred at 6:08 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Ralph W. Ballin		ADDRESS (Street, city or town, state) 62 Greene St. Cumberland, Md.	
NAME (Type) Ralph W. Ballin		DATE SIGNED 12-3-56	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF 12-5-56	22c. NAME OF CEMETERY OR CREMATORY St. Marys Cem.	22d. LOCATION (City, town, or county) (State) Cumberland, Md.
23. FUNERAL DIRECTOR'S SIGNATURE James E. Scannelli		24a. REC'D BY REGISTRAR Dec 3, 1956	
ADDRESS Cumberland, Md.		24b. REGISTRAR'S SIGNATURE W. K. Frank, M.D.	

THE HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, on page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BURMAN V. S.

DEC 4 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11958

CERTIFICATE OF DEATH

Reg. Dist. No.

DR. TOLSON

11967

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE PENNSYLVANIA b. COUNTY BEDFORD	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HYNDMAN	
c. LENGTH OF STAY IN 1b 10 DAYS		d. STREET ADDRESS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL & WARWICK AVES.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First CHARLES Middle H Last HARCLERODE		4. DATE OF DEATH Month DECEMBER Day 22 Year 1956	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1874 MARCH 9
9. AGE (In years last birthday) 82 yrs		10. IF UNDER 1 YEAR Months 1 Days 1	11. IF UNDER 24 HRS. Hours 1 Min 1
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Trackman		10b. KIND OF BUSINESS OR INDUSTRY P.R. Railroad Co.	
11. BIRTHPLACE (State or foreign country) HYNDMAN, PENNSYLVANIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JONATHAN HARCLERODE		14. MOTHER'S MAIDEN NAME ANNIE MILLER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT MEMORIAL HOSPITAL-CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerosis +50.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 1 DUE TO (c) ?		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Benign hypertrophy prostate		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. ft. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12-12-56 to 12-22-56 , that I last saw the deceased alive on 12-22-56 , and that death occurred at 8:50 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Howard K. Tolson M.D. Cumberland		DATE SIGNED 12-23-56	
PHYSICIAN'S NAME (Type) Howard K. Tolson Cumberland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Dec. 26, 1956	22c. NAME OF CEMETERY OR CREMATORY Hyndman Cemetery	22d. LOCATION (City, town, or county) (State) Hyndman, Pennsylvania.
23. FUNERAL DIRECTOR'S SIGNATURE Harvey H. Zeigler, Hyndman, Pennsylvania.		24a. REC'D BY REGISTRAR Dec 24, 1956	24b. REGISTRAR'S SIGNATURE W.L. Grant, M.D.

HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 shown, be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

U. S. A.

1947

RECEIVED

12010

CERTIFICATE OF DEATH

Reg. Dist. No.

9

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Ohio b. COUNTY Miami			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg				c. LENGTH OF STAY IN 1b 14 mos.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 69 Broadway				d. STREET ADDRESS Piqua			
3. NAME OF DECEASED (Type or print) LOU First Middle Last HARDESTY				4. DATE OF DEATH Dec. 13, 1956 Month Day Year			
5 SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-27-1873	9. AGE (In years last birthday) 83 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housework		10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) Piqua, Ohio		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Snavelly				14. MOTHER'S MAIDEN NAME Barbara Heffelman			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) none		16. SOCIAL SECURITY NO. none		17. INFORMANT Mrs. Robert Bachman, Frostburg, Md. Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH 25 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) XXXX		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) XXXX					
20c. TIME OF INJURY Month, Day, Year Hour a. m. XXX p. m. XXX		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) XXX		20f. (City or town) (County) (State) XXX	
21. I certify that I attended the deceased from Oct. 26, 1956 to Dec. 13, 1956 , that I last saw the deceased alive on Dec. 13, 1956 , and that death occurred at 11 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Martin M. Rothstein M.D.</i>				ADDRESS (Street, city or town, state) 48 Broadway			
PHYSICIAN'S NAME (Type) Martin M. Rothstein M.D.				Frostburg, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-17-56		22c. NAME OF CEMETERY OR CREMATORY Forest Hill Cemetery		22d. LOCATION (City, town, or county) (State) Piqua, Ohio	
23. FUNERAL DIRECTOR'S SIGNATURE J. R. Durst,				ADDRESS Frostburg, Md.		24a. REC'D BY REGISTRAR 12-14-56 24b. REGISTRAR'S SIGNATURE <i>Wm. M. N. R.</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU 9 8

1936

RECEIVED

12011 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miners Hospital				d. STREET ADDRESS 35 Grant St.			
3. NAME OF DECEASED (Type or print) First CLARA Middle (HARTIG) Last HARRIS				4. DATE OF DEATH Month Dec. Day 30 Year 1956			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12-8-1892	
9. AGE (In years last birthday) 64 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housework				10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME George Hartig				14. MOTHER'S MAIDEN NAME Mary K. Zais			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 214-01-6630D			
				17. INFORMANT Address Thos. Harris, Frostburg, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) carcinoma of pancreas & metastases 12/18 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Dec 30, 1956 to Dec 30, 1956 , that I last saw the deceased alive on Dec 30, 1956 , and that death occurred at 4:30 P.M. from the causes and on the date stated above. ACTUAL SIGNATURE J. B. Davis M.D. Frostburg, Md. 12-31-56 ADDRESS (Street, city or town, state) DATE SIGNED							
PHYSICIAN'S NAME (Type) Dr. John B. Davis							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-2-57		22c. NAME OF CEMETERY OR CREMATORY F'bg. Memorial Park		22d. LOCATION (City, town, or county) (State) Frostburg, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. R. Durst, Frostburg, Md.				24a. REC'D BY REGISTRAR DATE 1-1-57		24b. REGISTRAR'S SIGNATURE Miss Nancy N. De	

TO HOSPITAL OR ATTENDANT: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

EDWIN V. S.

NO

RECEIVED
JAN 10 1901

12012

CERTIFICATE OF DEATH

Reg. Dist. No.

9

1 PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frostburg</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Savage</u>			
c. LENGTH OF STAY IN 1b <u>1 day</u>				d. STREET ADDRESS <u>New Row</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Miners Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First <u>LULU</u> Middle <u>HARRIS</u> Last <u>HARRIS</u>		4. DATE OF DEATH Month <u>Dec.</u> Day <u>19,</u> Year <u>19 56</u>					
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-4-1888</u>	9. AGE (In years last birthday) <u>68</u> yrs	IF UNDER 1 YEAR Months <u>68</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	IF UNDER 24 HRS Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Saleslady</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Dept. store</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Samuel M. Kelly</u>				14. MOTHER'S MAIDEN NAME <u>Catherine Neal</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes, give war or dates of service)</u>		16. SOCIAL SECURITY NO <u>219-20-0537</u>		17. INFORMANT <u>Mrs. Stoner Beggs, Mt. Savage, Md.</u>			
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction, acute</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary Artery Heart Disease</u> DUE TO (c) <u>4 yrs.?</u>						INTERVAL BETWEEN ONSET AND DEATH <u>52 hrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>XXX</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>XXXX</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>XXXX</u>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>XXXX</u> p. m. <u>XXXX</u>		20d. INJURY OCCURRED While <u>XXXX</u> Not while <u>XXXX</u>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>XXXX</u>		20f. (City or town) (County) (State) <u>XXXX</u>	
21. I certify that I attended the deceased from <u>Dec. 17</u> , 19 <u>56</u> , to <u>Dec. 19</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Dec. 19</u> , 19 <u>56</u> , and that death occurred at <u>6 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>48 Broadway</u> DATE SIGNED <u>12/21/56</u>							
ACTUAL SIGNATURE <u>Martin M. Rothstein M.D.</u>		PHYSICIAN'S NAME (Type) <u>Martin M. Rothstein M.D.</u> <u>Frostburg, Md.</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-22-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Geo. Episcopal Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Mt. Savage, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. R. Durst, Frostburg, Md.</u>				24a. REC'D BY REGISTRAR <u>12-22-56</u>		24b. REGISTRAR'S SIGNATURE <u>Mrs. Nancy H. Roe</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

5

MADE IN
CHINA

1196S
CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY Allegany MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 11/30/56	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland	
		d. STREET ADDRESS 169 N. Centre St.	
3. NAME OF DECEASED (Type or print) Joseph M. Harrison		4. DATE OF DEATH Month December Day 13 Year 1956	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/12/1878
		9. AGE (In years last birthday) 78 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Janitor		10b. KIND OF BUSINESS OR INDUSTRY Church	11. BIRTHPLACE (State or foreign country) West Virginia
		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME T. D. Harrison		14. MOTHER'S MAIDEN NAME Susan H. Adams	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214 05 4708	
		17. INFORMANT P.O. Box 599 Address Cumberland, Md. Allegany County Infirmary Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Thrombosis 4200 DUE TO General arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Chronic myocarditis DUE TO (c) Perforating gastric ulcer			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Perforating gastric ulcer			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11/30/56 , 19 to 12/13/56 , 19, that I last saw the deceased alive on 12/13/56 , 19, and that death occurred at 8:20 A. M., from the causes and on the date stated above.			
ACTUAL SIGNATURE James E. McLean M.D.		ADDRESS (Street, city or town, state) 49 Greene St., DATE SIGNED 12/13/56	
PHYSICIAN'S NAME (Type) Dr. James E. McLean		Cumberland, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-15-1956	
22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE William H. Kight, Cumberland, Md.		24. REC'D BY REGISTRAR Dec 14, 1956	
		24b. REGISTRAR'S SIGNATURE W. K. Kight, M.D.	

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

DEC 19 1956

BUREAU V. 5

11969 CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY ALEEGANY		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE WEST VIRGINIA b. COUNTY ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 34 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES		d. STREET ADDRESS CUMBERLAND, ST.	
3. NAME OF FREDERICK DANIEL HEAVNER (Type or print) First Middle Last		4. DATE OF DEATH DECEMBER 26 1956 Month Day Year	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 22 1883
9. AGE (In years lost birthday) 73 yrs.		10. FUNDING 1 YEAR IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10b. KIND OF BUSINESS OR INDUSTRY STEEL Co.	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME DANIEL HEAVNER		14. MOTHER'S MAIDEN NAME KATHERINE MILLER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 214-05-9205	
17. INFORMANT Mrs. Clyde Simpson, Wiley Ford, W. Va.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Myocarditis DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 5 days 3 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Carcinoma of the Pancreas			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 22 Nov, 1956 to 26 Dec, 1956 , that I last saw the deceased alive on 25 Dec 1956 , and that death occurred at 8:40 AM from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE James B Stegmaier M.D.		122 So Centre St.	
PHYSICIAN'S NAME (Type) JAMES STEGMAIER		Cumberland, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Dec. 28, 1956	22c. NAME OF CEMETERY OR CREMATORY St. Lukes Cemetery	22d. LOCATION (City, town, or county) (State) Cumberland Md.
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George, Cumberland, Md.		24a. REC'D BY REGISTRAR 28, 1956 24b. REGISTRAR'S SIGNATURE W. L. Frank, M.D.	

THE MEDICAL CERTIFICATE OF DEATH is required to be filled out by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU N. S.

DEC 10 1954

12026 CERTIFICATE OF DEATH

Reg. Dist. No.

-8

1. PLACE OF DEATH a. COUNTY Allegany b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lonaconing c. LENGTH OF STAY IN 1b 75yrs. d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Charlestown Street		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Allegany c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lonaconing d. STREET ADDRESS Charlestown, Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JANETTE Middle HENDRA Last HENDRA 4. DATE OF DEATH Month DEC Day 5th. Year 1956		5. SEX Female 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH Aug, 9th. 1881 9. AGE (In years last birthday) 75 yrs. IF UNDER 1 YEAR: Months 75 Days 75 Hours 75 Min. 75	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Own Home 11. BIRTHPLACE (State or foreign country) Lonaconing, MD. 12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Hausman		14. MOTHER'S MAIDEN NAME Annie Martin	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO None 17. NEOMAN Address Mrs. Nelson Davis, Lonaconing, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Coronary Occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart disease DUE TO (c) many years		INTERVAL BETWEEN ONSET AND DEATH 24 hrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Cyril , 1956, to Dec , 1956, that I last saw the deceased alive on June , 1956, and that death occurred at 4 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Lonaconing, Md. DATE SIGNED Leslie R. Miles, Jr.			
ACTUAL SIGNATURE Leslie R. Miles, Jr. M.D. Lonaconing, Md.			
PHYSICIAN'S NAME (Type) Leslie R. Miles, Jr., M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec 8th. 1956	
22c. NAME OF CEMETERY OR CREMATORY Oak Hill Cemetery		22d. LOCATION (City, town, or county) (State) Lonaconing, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE GEORGE EICHORN, LONAC		24a. REC'D BY REGISTRAR 12/8/56 24b. REGISTRAR'S SIGNATURE Janette M. Boal	

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CHAU V. S.

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NEGATIVE

CERTIFICATE OF DEATH

11965

Reg. Dist. No. 4

11970

1. PLACE OF DEATH a. COUNTY <u>ALLEGANY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution, Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>ALLEGANY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CUMBERLAND</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CUMBERLAND</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>MEMORIAL Hosp.</u>				d. STREET ADDRESS <u>112 HENRY ST.</u>			
3. NAME OF DECEASED (Type or print) First <u>DONNA</u> Middle <u>ANN</u> Last <u>HILLEARY</u>				4. DATE OF DEATH Month <u>Dec.</u> Day <u>30</u> Year <u>1956</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 27-1956</u>	9. AGE (In years last birthday) yrs. <u>3</u>	IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>3</u> Days <u>3</u> Hours <u></u> Min. <u></u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>DONALD ROY HILLEARY</u>				14. MOTHER'S MAIDEN NAME <u>MARY E. SWAN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>MEMORIAL Hosp CUMB. MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Hemorrhagic Infarction of Lungs</u> DUE TO (b) <u>Patent interVentricular Septum</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u></u> PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fibrotic Pancreas</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>27 Dec</u> , 19 <u>56</u> , to <u>30 Dec</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>30 Dec</u> , 19 <u>56</u> , and that death occurred at <u></u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Leland B. Ransom</u> M.D.				ADDRESS (Street, city or town, state) <u>113 Gwynne St. Cumberland Md.</u>			
PHYSICIAN'S NAME (Type) <u>Leland B. Ransom, M.D.</u>				DATE SIGNED <u>Jan 2 1957</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>Dec. 31, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Louis Stein Inc. Cumberland Md.</u>				24a. REC'D BY REGISTRAR <u>W. K. Frantz, M.D.</u>		24b. REGISTRAR'S SIGNATURE	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. The funeral director, after this certificate has been signed by the attending physician and completely filled in, should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11971

CERTIFICATE OF DEATH

11966

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 16 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) MEMORIAL HOSPITAL				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First BESSIE Middle M. Last HINKLE				4. DATE OF DEATH Month DECEMBER Day 27 Year 1956			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCT. 16, 1889	9. AGE (In years last birthday) 67 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) MARYLAND, Green Ridge	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME MARTIN RILEY RILEY Riley Hartley				14. MOTHER'S MAIDEN NAME FRANCES LEIGHTY			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Joseph Silber Address Oldtown, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cordis aneurysm 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Hypertensive myocardial infarction with papillary muscle rupture DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cholecystitis with Cholelithiasis. Cholecystectomy 19 Dec. 56							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from 1 Oct. , 19 55 , to 27 Dec. , 19 56 , that I last saw the deceased alive on 27 Dec. 56 , and that death occurred at 5:30 P. M., from the causes and on the date stated above.							
ACTUAL SIGNATURE W. A. Van Ormer		M.D. Cumberland, Md.		ADDRESS (Street, city or town, state)		DATE SIGNED 29 Dec. 56	
PHYSICIAN'S NAME (Type) DR. W. A. VAN ORMER							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12/30/56	22c. NAME OF CEMETERY OR CREMATORY St. Olive Cemetery		22d. LOCATION (City, town, or county) (State) Allegany County, Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland		ADDRESS		24a. REC'D BY REGISTRAR Dec 30, 1956	24b. REGISTRAR'S SIGNATURE W. F. Frantz, M.D.		

BUREAU V. S.

RECEIVED

11972

CERTIFICATE OF DEATH

Reg. Dist. No

1 PLACE OF DEATH a. COUNTY Allegheny MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution- Residence before admission) a. STATE Maryland b. COUNTY Allegheny	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland,		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland,	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 456 N. Centre St.,		d. STREET ADDRESS 456 N. Centre St.,	
3. NAME OF DECEASED (Type or print) GRACE First BELVA Middle HISER Last		4. DATE OF DEATH Month December Day 8 Year 1956	
5 SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 26, 1885
9 AGE (In years last birthday) 71 yrs		IF UNDER 1 YEAR Months Days Hours	IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Partner in hiser Realty Co. Realty Co.		10b. KIND OF BUSINESS OR INDUSTRY Cumberland, Md.	
11. BIRTHPLACE (State or foreign country) U. S.		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME William G. Hiser		14. MOTHER'S MAIDEN NAME Mary McIntosh	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No,		16. SOCIAL SECURITY NO. None	
17. INFORMANT Miss. Aneva Hiser		Address 456 N. Centre St., Cumb. Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Vascular Accident 331x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from August, 1956 , to 17/8 , 19 56 , that I last saw the deceased alive on 17/7 , 19 56 , and that death occurred at 2:00 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Leo H. Ley Jr.		ADDRESS (Street, city or town, state) 456 N. Centre St.,	
DATE SIGNED 12/10/56			
PHYSICIAN'S NAME (Type) Leo H. Ley Jr. M. D.		Cumberland, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12/10/56	22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery	22d. LOCATION (City, town, or county) (State) Cumberland, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George		ADDRESS Cumberland, Md.	
24a. REC'D BY REGISTRAR 12/9/56		24b. REGISTRAR'S SIGNATURE W. L. Priddy, M.D.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 14 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove forban papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

1960

RECEIVED

11973

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegheny</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegheny</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. LENGTH OF STAY IN 1b <u>11 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Sacred Heart Hospital</u>		d. STREET ADDRESS <u>209 Milton Street</u>	
3. NAME OF DECEASED (Type or print) First <u>Nell</u> Middle <u>F.</u> Last <u>Hughes</u>		4. DATE OF DEATH Month <u>12</u> Day <u>10</u> Year <u>56</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-25-87</u>
9. AGE (In years last birthday) <u>69 yrs.</u>		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	11. IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Telephone operator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Baltimore and Ohio R.R.</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Joseph M. Hughes</u>		14. MOTHER'S MAIDEN NAME <u>Linna Damm</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>705 05 8136</u>	
17. INFORMANT <u>Patinets chart</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> <u>440X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Cerebral Vascular Disease</u> DUE TO (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u>15 days</u> <u>3</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Nov</u> , 19 <u>55</u> , to <u>Dec</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Dec 10</u> , 19 <u>56</u> , and that death occurred at <u>8:50 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>S. O. Himmelmright, M.D.</u>		ADDRESS (Street, city or town, state) <u> </u> DATE SIGNED <u>12.11.56</u>	
PHYSICIAN'S NAME (Type) <u>G. O. Himmelmright, M.D., 733 Virginia Ave., Cumberland, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12-13-56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Cumberland, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Right William H. Kight, Cumberland, Md.</u>		24a. REC'D BY REGISTRAR <u> </u> 24b. REGISTRAR'S SIGNATURE <u> </u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4

may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

DEC 14 1956

RECEIVED

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

4

11974

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Allegany		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) near- Cumberland (LaVale)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) at the Memorial Hospital			d. STREET ADDRESS R.F.D.#1 Braddock Farms		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Ralph Middle E. Last Hutzell			4. DATE OF DEATH Month Dec. Day 22 Year 19 56		
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 11-1914	9. AGE (In years last birthday) 42 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) lachinest helper		10b. KIND OF BUSINESS OR INDUSTRY B&O.R.Ry.		11. BIRTHPLACE (State or foreign country) Mt Savage, Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME John W. Hutzell		
14. MOTHER'S MAIDEN NAME Marietta Kaylor			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) yes <input checked="" type="checkbox"/> W.W. 2		
16. SOCIAL SECURITY NO. 215-10-1317			17. INFORMANT (father) John W. Hutzell, Mt. Savage, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shock due to loss of blood, lacerations DUE TO (b) of scalp, fractured right ramus and right Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) ankle also thrown several feet down to bed of Wills Creek.					INTERVAL BETWEEN ONSET AND DEATH sudden
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18) Walking, hit by a car on Wills Creek bridge & thrown to bed of creek.			
20c. TIME OF INJURY Month, Day, Year 315 Dec. 22 1956	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway Rt. 40	20f. (City or town) Cumberland	(County) Allegany	(State) Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and find that death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE H. V. Deming M.D.			M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) H. V. Deming M.D.			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Dec. 22-1956		
22a. BURIAL, CREMATION, or REMOVAL (Specify) Burial Dec. 27, 1956	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY Mt. Savage	22d. LOCATION (City, town, or county) (State) Md.		
23. FUNERAL DIRECTOR'S SIGNATURE J. R. Durst Frothing M.D.			24. REC'D BY REGISTRAR Dec 22, 1956		
ADDRESS			25. REGISTRAR'S SIGNATURE W. L. Frank, Md.		

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

THE GELLY
1911

within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

DR. HIMMELWRIGHT 1975

CERTIFICATE OF DEATH

Reg. Dist. No. 11970

1. PLACE OF DEATH a. COUNTY ALLEGANY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND, MD.		c. LENGTH OF STAY IN 1b 1 DAY	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL CUMBERLAND		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL			d. STREET ADDRESS ROUTE #4, Irons Mt		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First JOHN Middle M. Last IRONS			4. DATE OF DEATH Month DECEMBER Day 7 Year 19 56		
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APRIL 21, 1904		9. AGE (In years last birthday) 52 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Brick yard.	11. BIRTHPLACE (State or foreign country) MARYLAND Irons Mt		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME JOHN W. IRONS			14. MOTHER'S MAIDEN NAME CANDACE DICKEN		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-05-6951	17. INFORMANT Address MEMORIAL HOSPITAL - CUMBERLAND, MD.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple coronary disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH 2 weeks
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. ft. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from 19 54 to 19 56, that I last saw the deceased alive on 12 55, and that death occurred at 6:30 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED					
ACTUAL SIGNATURE [Signature] M.D. 133 11 19 56					
PHYSICIAN'S NAME (Type) DR. O. HIMMELWRIGHT					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 9, 1956	22c. NAME OF CEMETERY OR CREMATORY Davis Memorial Cem.		22d. LOCATION (City, town, or county) (State) Cumberland, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli			ADDRESS Cumberland, Md.		
24a. REC'D BY REGISTRAR DEC 9, 1956		24b. REGISTRAR'S SIGNATURE W. K. Frank, M.D.			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 of 1. This certificate has been signed by the attending physician and completely filled in. The funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

U. S. BUREAU

REC

DEC 1941

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12013

CERTIFICATE OF DEATH

11921

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>alleg.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frostburg</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frostburg</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>miners</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Golden William Jackson</u>		4. DATE OF DEATH Month Day Year <u>December 21 1956</u>	
5. SEX <u>M</u> COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 19 1956</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Frostburg, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>American</u>	
13. FATHER'S NAME <u>Richard L. Jackson</u>		14. MOTHER'S MAIDEN NAME <u>Dorothy Jane McLean</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Richard L. Jackson</u>		Address <u>Lowson 4th</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>774x Premature birth 7 1/2 mos.</u> DUE TO (b) <u>Cardiac failure.</u> DUE TO (c) <u>—</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>12-19</u> , 19 <u>56</u> , to <u>12-21</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>12-21</u> , 19 <u>56</u> , and that death occurred at <u>11:30 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>H.C. Diehl</u> M.D.		ADDRESS (Street, city or town, state) <u>Frostburg, Md</u> DATE SIGNED <u>12/22/56</u>	
PHYSICIAN'S NAME (Type) <u>H.C. Diehl M.D.</u>		<u>Frostburg, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12-22-56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Frostburg Mem. Park</u>	22d. LOCATION (City, town, or county) (State) <u>Frostburg, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>J.R. Hurst</u>		ADDRESS <u>Frostburg, Md</u>	
24a. REC'D BY REGISTRAR <u>—</u>		24b. REGISTRAR'S SIGNATURE <u>Wm. Nancy H. Rea</u>	

1295XV2

U. S. A.

RECEIVED

12014

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frostburg</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frostburg</u>			
c. LENGTH OF STAY IN 1b <u>Lifetime</u>				d. STREET ADDRESS <u>101 Wood Street</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>IOI Wood Street</u>				• IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Dora</u> Middle <u>Jenkins</u> Last <u>Jenkins</u>				4. DATE OF DEATH Month <u>12</u> Day <u>14</u> Year <u>1956</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1881</u>	9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House work</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Zihlman, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>George Eisel</u>				14. MOTHER'S MAIDEN NAME <u>Anna Martha Baum</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>None</u>			
17. INFORMANT <u>Mr. Philip Jenkins, Son.</u> Address <u>Frostburg, Md.</u>				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Sarcoma, abdominal</u> <u>199.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>199.1</u> DUE TO (c) <u>199.1</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>XXX</u>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>XXXX</u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>XXX</u> p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>XXX</u>	
				20f. (City or town) <u>XXX</u> (County) (State)			
21. I certify that I attended the deceased from <u>June 6</u> , 19 <u>56</u> , to <u>Dec. 14</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Dec. 14</u> , 19 <u>56</u> , and that death occurred at <u>2:55 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Martin M. Rothstein M.D.</u>				ADDRESS (Street, city or town, state) <u>48 Broadway</u>		DATE SIGNED <u>12/15/56</u>	
PHYSICIAN'S NAME (Type) <u>Martin M. Rothstein M.D.</u>				<u>Frostburg, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-17-1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Frostburg Mem. Park</u>		22d. LOCATION (City, town, or county) (State) <u>Frostburg Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Carl H. Mattingly, Frostburg, Md.</u>				24a. REC'D BY REGISTRAR <u>DATE 12-17-56</u>		24b. REGISTRAR'S SIGNATURE <u>Wm. Nancy H. Roe</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

EC 99 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11976 CERTIFICATE OF DEATH

11973

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution; Residence before admission) a. STATE WEST VIRGINIA b. COUNTY MINERAL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) KEYSER	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL		e. STREET ADDRESS 347 W. PIEDMONT STREET IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ELLIOTT Middle JENKINS Last JENKINS		4. DATE OF DEATH Month DEC. Day 23 Year 1956	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/29/1878
9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR Months 78 Days 78 Hours 78 Min. 78	IF UNDER 24 HRS. Hours 78 Min. 78
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED ENGINEER		10b. KIND OF BUSINESS OR INDUSTRY RAILROAD	11. BIRTHPLACE (State or foreign country) BENTONVILLE, VIRGINIA
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME GEORGE JENKINS THOMAS	
14. MOTHER'S MAIDEN NAME Adeline Paine		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. 705-07-6556		17. INFORMANT Address MEMORIAL HOSPITAL, CUMBERLAND, MARYLAND	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia DUE TO Perforating duodenal Ulcer Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last Chronic nephritis (b) Chronic nephritis (c) approx 1 year			INTERVAL BETWEEN ONSET AND DEATH 1 week 3 weeks approx 1 year
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Seriously			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 3:30		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov 29, 1956 to Dec 23, 1956 , that I last saw the deceased alive on Dec 23, 1956 , and that death occurred at 3:30 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE WYLIE M. FAW, JR.		ADDRESS (Street, city or town, state) Cumberland Md	
PHYSICIAN'S NAME (Type) XXXXXXXXXXXXXXXXXXXXXXX		DATE SIGNED Dec 28, 1956	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 26, 1956	
22c. NAME OF CEMETERY OR CREMATORY Queen's Point Cemetery		22d. LOCATION (City, town, or county) (State) Keyser, West Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE 13 W. Markwood		ADDRESS Keyser W. Va.	
24a. REC'D BY REGISTRAR Dec 24, 1956		24b. REGISTRAR'S SIGNATURE W. K. Frank, M.D.	

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

U. A. 1000

1000

1000

11977 **CERTIFICATE OF DEATH**

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		STATE <u>Maryland</u> COUNTY <u>Allegany</u>		CITY <u>Cumberland</u>		CITY <u>Cumberland</u>	
CITY <u>Cumberland</u>		TOWN <u>Cumberland</u>		STREET ADDRESS <u>217 Union Street</u>		STREET ADDRESS <u>217 Union Street</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>217 Union Street</u>		HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>217 Union Street</u>		HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>217 Union Street</u>		HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>217 Union Street</u>	
3. NAME OF DECEASED				4. DATE OF DEATH			
(First) <u>Albert</u> (Middle) <u>Melvin</u> (Last) <u>Kerns Sr.</u>				Month <u>12</u> Day <u>25</u> Year <u>1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>		8. DATE OF BIRTH <u>Sept. 19- 1901</u>	
9. AGE last birthday <u>55</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machinist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad B&O</u>		11. BIRTHPLACE (State or foreign country) <u>Potomac Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>Freedland Sandland Kerns</u>			
14. MOTHER'S MAIDEN NAME <u>Ella Robinson</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>Yes</u> (If Yes, give war or dates of service) <u>WWI</u>			
16. SOCIAL SECURITY NO. <u>705-09-9759</u>				17. INFORMANT & ADDRESS <u>Mrs. Katherine M. Kerns</u>			
18. MEDICAL CERTIFICATION				19. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Ventricular Fibrillation Thrombosis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>immediate</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Coronary Artery disease</u>				INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Coronary Artery disease</u>				INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs</u>			
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>—</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
19a. DATE OF OPERATION <u>—</u>		19b. MAJOR FINDINGS OF OPERATION <u>—</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) <u>—</u>		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>—</u>		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR? <u>—</u>		21f. HOW DID INJURY OCCUR? <u>—</u>	
22. I hereby certify that I attended the deceased from <u>3/11/54</u> 19....., to <u>12/25/56</u> 19....., that I last saw the deceased alive on <u>12/23/56</u> 19..... and that death occurred at <u>7:30</u> M, from the causes and on the date stated above.							
SIGNATURE <u>Richard P. Williams M.D.</u>				ADDRESS (Street, city, town, state) <u>Cumberland Maryland</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Dec. 28-1956</u>		NAME OF CEMETERY OR CREMATORY <u>Hillcrest Cemetery</u>		LOCATION (City, town, or county) <u>Cumberland Maryland</u>	
24. REC'D BY REGISTRAR <u>Dec 27, 1956</u>		REGISTRAR'S SIGNATURE <u>W. L. Frantz M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Louis Stein</u>		DATE SIGNED <u>12/27/56</u>	

INSTRUCTIONS

1. WITHIN 24 HOURS AFTER DEATH. The law requires that the death certificate be executed within 24 hours after death.

2. TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

3. TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M



11978

CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland			c. LENGTH OF STAY IN 1b 44 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 312 Arch Street				d. STREET ADDRESS 312 Arch Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Royle Middle P. Last Lapp				4. DATE OF DEATH Month Dec. Day 22 Year 19 56			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 3, 1897		9. AGE (In years last birthday) yrs 59	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic		10b. KIND OF BUSINESS OR INDUSTRY Railroad		11. BIRTHPLACE (State or foreign country) Frostburg, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Conrad E. Lapp				14. MOTHER'S MAIDEN NAME Margaret Pengelly			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 705-10-3646		17. INFORMANT Address Mrs. Hazel Lapp, Cumberland, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Myocarditis DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 2 mon.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Dec. 1, 1956 , to Dec. 22, 1956 , that I last saw the deceased alive on Dec. 21, 1956 , and that death occurred at 5:15 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Clay E. Durrett			ADDRESS (Street, city or town, state) 736 Virginia Ave			DATE SIGNED 12/22/56	
PHYSICIAN'S NAME (Type) Clay E. Durrett							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 24, 1956		22c. NAME OF CEMETERY OR CREMATORY Eckhart, Cemetery		22d. LOCATION (City, town, or county) (State) Eckhart, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli				ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR Dec. 24, 1956	
				24b. REGISTRAR'S SIGNATURE W. R. Grant, M.D.			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

U. S. A. 1920

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STATE OF

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11977

Reg. Dist. No.

12027

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE Md. b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural Midland				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural-Midland			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First Martha Middle H. Last Lease				4. DATE OF DEATH Month Dec. Day 8 Year 19 56			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 17-1877		9. AGE (In years last birthday) 79 yrs.	IF UNDER 1 YEAR Months Days 	IF UNDER 24 HRS. Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Rawlings, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Henry Hacker				14. MOTHER'S MAIDEN NAME Ellen McKenzie			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT (son) Henry Lease, Midland, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized arteriosclerosis DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) DUE TO cause lost, (c) 							INTERVAL BETWEEN ONSET AND DEATH Gradual
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE H. V. Deming M.D.				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) H.V. Deming M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Dec. 8-1956	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/10/1956		22c. NAME OF CEMETERY OR CREMATORY Laurel Hill Cemetery		22d. LOCATION (City, town, or county) (State) Moscow, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE George Eichhorn, Lonaconing, MD.				24a. REC'D BY REGISTRAR 12/10/56		24b. REGISTRAR'S SIGNATURE Janette M. Boal	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

UNITED STATES

OF

POSTAL SERVICE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11978

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frostburg</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frostburg</u>			
c. LENGTH OF STAY IN 1b <u>12 Yrs.</u>				d. STREET ADDRESS <u>19 E. Main St.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>19 E. Main St.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Logeer</u> Last <u>Logeer</u>				4. DATE OF DEATH Month <u>12</u> Day <u>1</u> Year <u>1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5-17-1897</u>	
9. AGE (In years, last birthday) <u>59 yrs.</u>		IF UNDER 1 YEAR Months <u>1</u> Days <u>1</u>		IF UNDER 21 YRS. Hours <u>56</u> Min. <u>56</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retrucker Driver</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Truck</u>		11. BIRTHPLACE (State or foreign country) <u>Vale Summit Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>George Legeer</u>				14. MOTHER'S MAIDEN NAME <u>Laura Loar</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>				16. SOCIAL SECURITY NO. <u>28T-14-3034</u>			
17. INFORMANT <u>Ruth Williams Legeer, Wife</u>				Address <u>19 E. Main St. Frostburg, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronis Myocarditis</u> DUE TO (c) <u>Sudden</u> 35 yrs.							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural cause <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>H. V. Deming M.D.</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>H. V. Deming M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Dec. 1-1956</u>			
22a. BURIAL, CREMATION, or other disposal (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Dec. 3-1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Frostburg Memorial Park</u>		22d. LOCATION (City, town, or county) (State) <u>Frostburg, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Dean H. Hutterling, Jr., M.D.</u> ADDRESS				24a. REC'D BY REGISTRAR <u>Dec 12-3-56</u>		24b. REGISTRAR'S SIGNATURE <u>Dean H. Hutterling, Jr.</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file.

У А ПУРНО

СТА

Items 8 & 9, Film G209, 1/7/57 **CERTIFICATE OF DEATH**

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland				c. LENGTH OF STAY IN 1b 5 weeks			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Memorial Hospital				e. STREET ADDRESS 226 Humbird Street			
3. NAME OF DECEASED (Type or print) First Fred Middle Marshall Last Light				4. DATE OF DEATH Month Dec. Day 22 Year 19 56			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 26, 1878	9. AGE (In years last birthday) 77 yrs	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS. Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) Points, W. Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles Light				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 236-50-0117		17. INFORMANT Mr. Charles Light, Cumberland, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 4 1/2 hrs 5 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Mar. 25, 1956 to Dec. 22, 1956 ; that I last saw the deceased alive on Dec. 22, 1956 , and that death occurred at 3 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 236 Va. Ave DATE SIGNED 12/22/56 ACTUAL SIGNATURE Clay E. Durrett M.D. PHYSICIAN'S NAME (Type) Clay E. Durrett							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 24, 1956		22c. NAME OF CEMETERY OR CREMATORY Davis Memorial		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Md.				24a. REC'D BY REGISTRAR Dec. 24, 1956		24b. REGISTRAR'S SIGNATURE W. L. Hantz, M.D.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

3 A 017007

92 H 1 00

007 A 017007

12028 CERTIFICATE OF DEATH

Reg. Dist. No. 11880

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Id.</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Barton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Barton</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Latrobe St</u>		d. STREET ADDRESS <u>Latrobe</u>	
3. NAME OF DECEASED (Type or print) <u>Mary</u> First <u>Ann</u> Middle <u>Logsdon</u> Last		4. DATE OF DEATH <u>Dec. 28</u> Month <u>28</u> Day <u>19</u> Year <u>56</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>23 Nov. 1964</u>
9. AGE (In years last birthday) <u>92</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Scotland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John McGimpsey</u>		14. MOTHER'S MAIDEN NAME <u>Martha Ann (McGimpsey)</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>William Logsdon- Barton, Id.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH CAUSED BY IMMEDIATE CAUSE (a) <u>Gastric Hemorrhage</u> <u>151X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma of Stomach</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>2 Days</u> <u>Unknown</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Dec. 25, 1956</u> , to <u>Dec. 26, 1956</u> , that I last saw the deceased alive on <u>Dec. 26, 1956</u> , and that death occurred at <u>11:00 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Paul R. Wilson</u> M.D.		ADDRESS (Street, city or town, state) <u>Piedmont, W. Va.</u> DATE SIGNED <u>Dec. 27, 1956</u>	
PHYSICIAN'S NAME (Type) <u>Paul R. Wilson M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12/29/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Laurel Hill Cem</u>	22d. LOCATION (City, town, or county) (State) <u>Moscow, Id.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>E. L. Brown</u> ADDRESS <u>Westernport, Id.</u>		24a. REC'D BY REGISTRAR DATE <u>12-28-56</u>	24b. REGISTRAR'S SIGNATURE <u>Jean C. Kelly</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1956

1956

1956

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11981

DR. JACOBSON

11980 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Res. dence before admission) a STATE MARYLAND b COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 2 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LONA CONING	
d. NAME OF HOSPITAL (If not in hospital, give street address) MEMORIAL HOSPITAL				d. STREET ADDRESS E. MAIN STREET		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First WILLIAM Middle MARSHALL, JR. Last DECEASED				4. DATE OF DEATH Month DECEMBER Day 15 Year 1956			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH SEPT. 13, 1900	
9. AGE (In years last birthday) 56 yrs		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>		IF UNDER 24 HRS. Hours <input type="checkbox"/> Min <input type="checkbox"/>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CONTRACTOR & Gen'l. Mgr. Lumber Co.				10b. KIND OF BUSINESS OR INDUSTRY MARYLAND		11. BIRTHPLACE (State or foreign country) U.S.A.	
13. FATHER'S NAME WILLIAM MARSHALL, SR.				14. MOTHER'S MAIDEN NAME RACHAEL SMITH			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. MEMORIAL HOSPITAL - CUMBERLAND, MD.			
17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Left Ventricular Failure							Immediate
420.1 DUE TO							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
(b) Myocardial Fibrosis							?
DUE TO							
(c) Coronary Arteriosclerosis							?
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
Virus pneumonia 1/2 right middle lobe							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from 12-13-56 , 19 56 , to 12-15-56 , 19 56 , that I last saw the deceased alive on 12-15-56 , 19 56 , and that death occurred at 11:10 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Samuel Jacobson				ADDRESS (Street, city or town, state) 50 Pershing St., Cumberland, Md.			
PHYSICIAN'S NAME (Type) DR. SAMUEL JACOBSON				DATE SIGNED 12-1-56			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nec. 19, 1956		22c. NAME OF CEMETERY OR CREMATORY Frostburg Memorial Park		22d. LOCATION (City, town, or county) (State) Frostburg, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE George E. Eubank				ADDRESS Lonsconing Md		24. REC'D BY REGISTRAR Dec. 17, 1956	
				24b. REGISTRAR'S SIGNATURE W.R. Frank, M.D.			

BUREAU V. 3.

DEC 19 1956

RECEIVED

Within corporate limits

11981

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY ALLEGANY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 33 DAYS		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		d. STREET ADDRESS #2 MAPLE STREET		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First AGNES Middle V. Last MATT		4. DATE OF DEATH Month DECEMBER Day 18 Year 1956		5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH DEC. 8 1877		9. AGE (In years last birthday) 79 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min		11. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) CUMBERLAND, MARYLAND				12. CITIZEN OF WHAT COUNTRY? U.S.A.									
13. FATHER'S NAME PETER COSGROVE				14. MOTHER'S MAIDEN NAME MARTHA JUDY													
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT MRS. JANE LEASURE, CUMBERLAND, MD.				Address									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Stomach with 151X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) metastasis to liver DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH approx 6 months approx 4 months							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)															
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Cumberland, Md.		(County)		(State)							
21. I certify that I attended the deceased from Nov 15, 1956 to Dec 18, 1956 , that I last saw the deceased alive on Dec 18, 1956 , and that death occurred at 7:50 AM , from the causes and on the date stated above.																	
ACTUAL SIGNATURE James F. Scarpelli		M.D. Cumberland, Md.		ADDRESS (Street, city or town, state) Cumberland, Md.		DATE SIGNED Dec 19, 1956											
PHYSICIAN'S NAME (Type) James F. Scarpelli																	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-21-56		22c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery		22d. LOCATION (City, town, or county) Cumberland, Md.		(State)									
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Md.		ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR Dec 21, 1956		24b. REGISTRAR'S SIGNATURE Walter S. Gault, Jr.											

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

1956

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RECEIVED

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 4

12085

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Highway Rt. 40</u>				d. STREET ADDRESS <u>113 Decatur St.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Carl Price McDonald</u>				4. DATE OF DEATH Month Day Year <u>Dec. 15 19 56</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 6-1900</u>		9. AGE (In years last birthday) <u>56</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machinest</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>B&O R.Ry.</u>		11. BIRTHPLACE (State or foreign country) <u>Cumberland, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Mc Donald</u>				14. MOTHER'S MAIDEN NAME <u>Cora Price</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>705-05-5283</u>		17. INFORMANT Address <u>wife-Anona Talley McDonald, Cumberland, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ruptured heart, intrathoracic hemorrhage due-</u> sudden <u>816X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>a crushed chest.</u> (c) <u>_____</u> DUE TO (a), stating the underlying cause last. (c) <u>_____</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>_____</u> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury, part of body injured, and date of injury) <u>head on with another car.</u>					
20c. TIME OF INJURY Month, Day, Year <u>11.05 a.m. Dec. 15 1956</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>near Highway Rt 40</u>		20f. (City or town) (County) (State) <u>Cumberland Allegany Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>H. V. Deming M.D.</u>				DATE SIGNED M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Dec. 16-1956</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Dec. 19, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Hyndman Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hyndman, Pennsylvania.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hafer's Funeral Service, Cumberland, Maryland.</u>				24a. REC'D BY REGISTRAR <u>Dec. 17, 1956</u>		24b. REGISTRAR'S SIGNATURE <u>W. L. Frantz M.D.</u>	

Outside of
City Limits

near

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BUREAU V. S.

DEC 10 1900

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11982

CERTIFICATE OF DEATH

11984

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE PENNSYLVANIA b. COUNTY SOMERSET			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 18 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL, MEMORIAL & WARWICK AVES.				d. STREET ADDRESS 725 MAIN STREET			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First WILLIAM Middle A. Last MC LUCKIE				4. DATE OF DEATH Month DECEMBER Day 22 Year 1956			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH SEPT. 10, 1875		9. AGE (In years last birthday) 81 yrs	IF UNDER 1 YEAR Months 8 Days 12 Hours 15 Min.	IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY Own Farm		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ROBERT MC LUCKIE				14. MOTHER'S MAIDEN NAME EMMA ANGIN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Memorial Hospital			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerosis with myocardial degeneration DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ? DUE TO (c) Benign hypertrophy prostate				INTERVAL BETWEEN ONSET AND DEATH ?			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. ft. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12-4-56 , 19 56 , to 12-22-56 , 19 56 , that I last saw the deceased alive on 12-22-56 , 19 56 , and that death occurred at 12:25 PM from the causes and on the date stated above.							
ACTUAL SIGNATURE Howard L. Tolson M.D. Cumberland, Md.				ADDRESS (Street, city or town, state) 12-23-56			
DATE SIGNED							
PHYSICIAN'S NAME (Type) HOWARD L. TOLSON							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 12-26-56		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY W.C.F. Cemetery		22d. LOCATION (City, town, or county) (State) Berlin Somerset Co. Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE H.L. Johnson				ADDRESS Berlin, Pa.		24a. REC'D BY REGISTRAR Dec 24, 1956	
				24b. REGISTRAR'S SIGNATURE W.R. Granty M.D.			

LIBRARY V. 3

1950-1951

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11985

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Eckhart				c. LENGTH OF STAY IN 1b 35yrs.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) R. F. D. I Frostburg, Md.				e. STREET ADDRESS R. F. D. I Frostburg, Md.			
3. NAME OF DECEASED (Type or print) First Middle Last Florence Miller				4. DATE OF DEATH Month Day Year Dec. 1st 1956			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 6th., 1897	
9. AGE (In years last birthday) 59 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Eckhart, Md.	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Louis Niner		14. MOTHER'S MAIDEN NAME Florence Shipley			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Miner's Hospital Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion, DUE TO Coronary Sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) ? DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH Sudden
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE H. V. Deming M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) H. V. Deming, M. D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Dec. 2nd., 1956			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-4-1956		22c. NAME OF CEMETERY OR CREMATORY St. Michaels Cemetery		22d. LOCATION (City, town, or county) (State) Frostburg, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Paul H. Mattingly				24a. REC'D BY REGISTRAR 12-4-56			
				24b. REGISTRAR'S SIGNATURE Miss Nancy N. Roe			

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11983

CERTIFICATE OF DEATH

Reg. Dist. No. 11986

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND			2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland			c. LENGTH OF STAY IN 1b Cumberland		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 221 Avirett Ave.			d. STREET ADDRESS 221 Avirett Ave.		
3. NAME OF DECEASED (Type or print) First ELLEN Middle AGATHA Last MORGAN			4. DATE OF DEATH Month Dec. Day 22, Year 19 56		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/4/1885		9. AGE (In years last birthday) 71 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Ocean, Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.			13. FATHER'S NAME Timothy Byrne		
14. MOTHER'S MAIDEN NAME Sarah Cullen			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		
16. SOCIAL SECURITY NO. None			17. INFORMANT Mr. Robert A. Morgan Address Cumberland, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL HEMORRHAGE—Recent DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Cerebral arteriosclerosis (c) Old cerebral hemorrhage INTERVAL BETWEEN ONSET AND DEATH 10 MIN. 54. 1 year					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ARTERIOSCLEROTIC HEART DISEASE					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 56		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from 19 53 , to 12/22 , 19 56 , that I last saw the deceased alive on 12/20 , 19 56 , and that death occurred at 2:00 P.M. from the causes and on the date stated above.					
ACTUAL SIGNATURE S G WEISMAN M.D.		ADDRESS (Street, city or town, state) 19 Greene St		DATE SIGNED 12/24/56	
PHYSICIAN'S NAME (Type) S G WEISMAN		Cumberland, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/26/1956		22c. NAME OF CEMETERY OR CREMATORY S.S. Peter & Paul Cem.	
22d. LOCATION (City, town, or county) Cumberland, Md.		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George			ADDRESS Cumberland, Md.		
24a. REC'D BY REGISTRAR Dec. 26, 1956		24b. REGISTRAR'S SIGNATURE W.R. Frantz, M.D.			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED V. 2

RECEIVED V. 2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS AIS (4)
15M 9/55

DR. R.J. WMS.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11984 CERTIFICATE OF DEATH

11987

Reg. Dist. No.

1. PLACE OF DEATH a COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a STATE MARYLAND b COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 6 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL		d STREET ADDRESS 209 NORTH CENTRE ST.	
3. NAME OF DECEASED (Type or print) First HARRY Middle T RUMAN Last MYERS		4. DATE OF DEATH Month DEC. Day 24 Year 1956	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/29, 1896
9. AGE (In years last birthday) 60 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	11. IF UNDER 24 HRS Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TAILOR		10b. KIND OF BUSINESS OR INDUSTRY Mending Clothes	
11. BIRTHPLACE (State or foreign country) MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME MYERS, JOSEPH E.		14. MOTHER'S MAIDEN NAME SIGLER, ELLA	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 214-05-4537	
17. INFORMANT MEMORIAL HOSPITAL		Address MEMORIAL & WARWICK AVES.	
18. CAUSE OF DEATH [Enter only one cause pertinent for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Lung 16.5 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 6 mos.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7/24/56 , 19 to 12/24/56 , 19, that I last saw the deceased alive on 12/23/56 , 19, and that death occurred at 3:00 M, from the causes and on the date stated above.			
ACTUAL SIGNATURE DR. R.J. WMS.		ADDRESS (Street, city or town, state) DATE SIGNED Cumberland, Md. 12/25/56	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec 26 1956	
22c. NAME OF CEMETERY OR CREMATORY Frostburg Memorial Park		22d. LOCATION (City, town, or county) (State) Frostburg, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE William H. Kight		ADDRESS Cumberland, Md.	
24a. REC'D BY REGISTRAR Dec 26, 1956		24b. REGISTRAR'S SIGNATURE W.R. Frantz, M.D.	

U.S. DEPARTMENT OF AGRICULTURE

Soil Conservation Service

OFFICE OF THE DIRECTOR
WASHINGTON, D.C.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11988

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Ma b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 22 Frostburg				c. LENGTH OF STAY IN 1b 8 yrs.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 76 W. Mechanic St.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First John Middle Raymond Last Naughton				4. DATE OF DEATH Month Dec. Day 22 Year 1956			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 7-1917		9. AGE (In years last birthday) 39 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer * Hazelwood Construction				10b. KIND OF BUSINESS OR INDUSTRY Mt. Savage, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME Geneive Naughton			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes W.W. 2				16. SOCIAL SECURITY NO. 213-12-9806			
17. INFORMANT (wife) Helen McKenzie Naughton, Frostburg				Address Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary occlusion DUE TO Coronary sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ? DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH sudden							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE H. V. Deming M.D.				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) H. V. Deming M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Dec. 22-1956			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
BURIAL		Dec 24-1956		St Anne		Sanct Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph R. Deenot				24a. REC'D BY REGISTRAR 12-24-56		24b. REGISTRAR'S SIGNATURE Mrs. Mary H. Ross	

1. DUTY MEDICAL EXAMINER: This certificate should be completed within 24 hours after death. If any delay is necessary, please excuse the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

RECEIVED

DEC 31 1956

DEC 31 1956

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11985

CERTIFICATE OF DEATH

11989

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 6/9/51	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary		d. STREET ADDRESS Algonquin Hotel	
3. NAME OF DECEASED (Type or print) First Theadocia Middle Sowers Last Pitzer		4. DATE OF DEATH Month December Day 14 , Year 19 56	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/15/1878
9. AGE (in years last birthday) 78 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY House	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Jacob Sowers		14. MOTHER'S MAIDEN NAME Mary Elizabeth Keysar	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT P. O. Box 599 Address Cumberland, Md.		18. Allegany County Infirmary Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema 42:2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral Arteriosclerosis DUE TO (c) Chronic Myocarditis			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteritis Deformans			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6/9/51 , 19____, to 12/14/56 , 19____, that I last saw the deceased alive on 12/14/56 , 19____, and that death occurred at 8:25 P M, from the causes and on the date stated above.			
ACTUAL SIGNATURE James E. McLean M.D.		ADDRESS (Street, city or town, state) 49 Greene St., DATE SIGNED 12/15/56	
PHYSICIAN'S NAME (Type) Dr. James E. McLean		Cumberland, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Dec 17 1956	22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery	22d. LOCATION (City, town, or county) (State) Cumberland Md.
23. FUNERAL DIRECTOR'S SIGNATURE William H. Right, ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR Dec 16, 1956 24b. REGISTRAR'S SIGNATURE W.R. Frantz, M.D.	

DEC 19 1940

RECEIVED

BUREAU V. S.

12017 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Md. b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg			
c. LENGTH OF STAY IN 1b 1 day				d. STREET ADDRESS R. D. No 2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miner's Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last George H. Plummer				4. DATE OF DEATH Month Day Year 12-14-1956			
5. SEX M.	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 18th., 1881		9. AGE (In years last birthday) 75 yrs		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic		10b. KIND OF BUSINESS OR INDUSTRY Own Shop		11. BIRTHPLACE (State of foreign country) Frostburg		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME David H. Plummer				14. MOTHER'S MAIDEN NAME Carolin Seaton			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Custer Plummer, R. D. No 2 Frostburg, Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 446X DUE TO Uremia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Nephritis DUE TO (c) Arteriosclerosis						INTERVAL BETWEEN ONSET AND DEATH 24 hrs. 2 weeks years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Nov. 29, 1956 , to Dec. 14, 1956 , that I last saw the deceased alive on Dec. 14, 1956 , and that death occurred at 5:40 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE John B. Davis , M.D.				ADDRESS (Street, city or town, state) 2 Broadway, Frostburg, Md			
PHYSICIAN'S NAME (Type) John B. DAVIS, MD.				DATE SIGNED 12/14/56			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-16-1956		22c. NAME OF CEMETERY OR CREMATORY Frostburg Mem. Park		22d. LOCATION (City, town, or county) (State) Frostburg Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles H. Mattingly ADDRESS Frostburg, Md				24a. REC'D BY REGISTRAR DATE 12-16-56		24b. REGISTRAR'S SIGNATURE Miss Mary X. Roe	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

6948

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland, rural</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Potomac river, near Kelly's Island,</u>				e. STREET ADDRESS <u>309 Grand Ave.</u>			
3. NAME OF DECEASED (Type or print) First <u>R.F.D. #4</u> Middle <u>Jane</u> Last <u>Propst</u>				4. DATE Month <u>Dec.</u> Day <u>10</u> Year <u>19 56</u>			
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 23, 1918</u>		9. AGE (In years last birthday) <u>38</u> yrs.	10. IF UNDER 1 YEAR Months <u>18</u> Days <u>28</u> Hours <u>00</u> Min. <u>00</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Employee</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Cumberland Macaroni Mfg</u>		11. BIRTHPLACE (State or foreign country) <u>Mathias, W.Va.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Felix Jenkins</u>				14. MOTHER'S MAIDEN NAME <u>Minnie Despany</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>214-07-0143</u>			
17. INFORMANT <u>Mrs. Frank Robertson, Old Town, Md.</u>				Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia</u> <u>Presume-</u> DUE TO <u>drowning</u> Conditions, if any, which gave rise to immediate cause (b) <u> </u> (c), stating the underlying cause lost. DUE TO <u> </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Two weeks before her final disappearance, she left a note, planning suicide.</u>			
20c. TIME OF INJURY Hour <u> </u> a. m. <u> </u> p. m. <u> </u> <u>about Dec. 10 1956</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Potomac River, Cumberland, Allegany Md.</u>	
20f. (City or town) <u>Cumberland</u>				20g. (County) <u>Allegany</u>		20h. (State) <u>Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>H. V. Deming M.D.</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>H.V. Deming M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Aug. 6-1957</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug. 7, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Davis Memorial Park</u>		22d. LOCATION (City, town, or county) (State) <u>near Cumberland, Maryland.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. Lee Silcox, Cumberland, Maryland.</u>				ADDRESS <u> </u>		24a. REC'D BY REGISTRAR <u>Aug 8, 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>A. Ross Cameron</u>		Acting Registrar	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

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may be relied upon by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or inhumation, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11991

11986 CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland				c. LENGTH OF STAY IN 1b Life			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 28 Greene Street				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Daniel Middle Augusta Last Porter				4. DATE OF DEATH Month Dec. Day 20 Year 1956			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/30/1866		9. AGE (In years last birthday) 90 yrs.	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman Retired		10b. KIND OF BUSINESS OR INDUSTRY Paint, Supply		11. BIRTHPLACE (State or foreign country) Maryland Rawling		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Wm. A. Porter				14. MOTHER'S MAIDEN NAME Sarah Brown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-14-7540		17. INFORMANT Richard A. Porter Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 430.0 Congestive heart failure DUE TO (b) arteriosclerotic heart disease DUE TO (c) arteriosclerosis							INTERVAL BETWEEN ONSET AND DEATH 6 weeks 1 year 2 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12-7- , 19 56 , to 12-8- , 19 56 , that I last saw the deceased alive on 12-7- , 19 56 , and that death occurred at 6:45 A. M., from the causes and on the date stated above.							
ACTUAL SIGNATURE L. Brings				ADDRESS (Street, city or town, state) 57 Greens M. DATE SIGNED			
PHYSICIAN'S NAME (Type) LEWIS BRINGS				Cumberland Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12-10-56	22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cem.		22d. LOCATION (City, town, or county) (State) Cumberland, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli ADDRESS Cumberland, Md.				24a. REC'D BY REGISTRAR Dec. 9, 1956		24b. REGISTRAR'S SIGNATURE W. A. Frank, M.D.	

BUREAU V. 3

DEC 1

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

DR. WHITWORTH

11987 CERTIFICATE OF DEATH

11992

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 2 DAYS			
d. NAME OF HOSPITAL (if not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL				e. STREET ADDRESS R.F.D.#1, CASH VALLEY ROAD			
3. NAME OF DECEASED (Type or print) First BRIAN Middle KEITH Last PROUD				4. DATE OF DEATH Month DECEMBER Day 15 Year 19 56			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH DECEMBER 13, 1956		9. AGE (In years last birthday) yrs 2	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) CUMBERLAND, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME RONALD H. PROUD				14. MOTHER'S MAIDEN NAME BETTY L. SHORT			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 1 one		17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 762.0 DUE TO Alcoholism Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 1:30 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED DR. F.B. WHITWORTH 11 Dec 56							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 17, 1956		22c. NAME OF CEMETERY OR CREMATORY S.S. Peter & Pauls Cemetery		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George, Cumberland, Md.				24a. REC'D BY REGISTRAR Dec 16, 1956		24b. REGISTRAR'S SIGNATURE W. L. Frantz, M.D.	

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BUREAU V. S.

DEC 10 1956

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12018

CERTIFICATE OF DEATH

Reg. Dist. No.

9

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Garrett			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg				c. LENGTH OF STAY IN 1b 11 wks.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miners Hospital				d. STREET ADDRESS Frostburg, Rt. 2,			
3. NAME OF DECEASED (Type or print) First Middle Last FLORENCE (WARNER) ROSENBERGER				4. DATE OF DEATH Month Day Year Dec. 7, 19 56			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7-13-1879	
9. AGE (In years last birthday) yrs. 77		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housework		10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) Pennsylvania	
10c. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Washington Warner		14. MOTHER'S MAIDEN NAME Nancy Engle			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service		16. SOCIAL SECURITY NO. none		17. INFORMANT Address Rt. 2, Clarence Rosenberger, Frostburg, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DISEASE INTESTINAL PHOSPHORY FIBROSIS DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) URICEMIA DUE TO (c) RENAL FAILURE							INTERVAL BETWEEN ONSET AND DEATH 6 WEEKS 2 WEEKS
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug 6, 1956 , to Dec 7, 1956 , that I last saw the deceased alive on Dec 6, 1956 , and that death occurred at M , from the causes and on the date stated above.							
ACTUAL SIGNATURE John C. Devers M.D.				ADDRESS (Street, city or town, state) 134 E MAIN		DATE SIGNED 12/8/56	
PHYSICIAN'S NAME (Type) John C. Devers MD				Frostburg, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-10-56		22c. NAME OF CEMETERY OR CREMATORY Greenville Cemetery		22d. LOCATION (City, town, or county) (State) Greenville, Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE J. R. Durst,				ADDRESS Frostburg, Md.		24a. REC'D BY REGISTRAR DATE 12-10-56	
				24b. REGISTRAR'S SIGNATURE Mrs. Nancy H. Poe			

MEDICAL CERTIFICATION

BUREAU V. 3

DEC 14 1956

RECEIVED

12019

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o STATE Maryland b. COUNTY Garrett			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg				c. LENGTH OF STAY IN 1b 3 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miners Hospital				d. STREET ADDRESS Frostburg, Rt. 2,			
3. NAME OF DECEASED (Type or print) First JAMES Middle LOUIS Last ROSENBERGER				4. DATE OF DEATH Month Dec. Day 30, Year 19 56			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-16-1883		9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Saw Mill operator		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Godfrey Rosenberger				14. MOTHER'S MAIDEN NAME Margaret Bittner			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. none		17. INFORMANT Elmer Rosenberger, Frostburg Rt. 2, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive Cardio-vascular disease DUE TO (c) disease						INTERVAL BETWEEN ONSET AND DEATH 4 days 5 years.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from 12-26 , 19 56 , to 12-30 , 19 56 , that I last saw the deceased alive on 12-30 , 19 56 , and that death occurred at 5:15 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE H. C. Diehl				ADDRESS (Street, city or town, state) W. Main St., Frostburg, Md.			
DATE SIGNED 12/31/56							
PHYSICIAN'S NAME (Type) Dr. H. C. Diehl							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-2-1957		22c. NAME OF CEMETERY OR CREMATORY Finzel Cemetery		22d. LOCATION (City, town, or county) (State) Finzel, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. R. Durst, Frostburg, Md.				ADDRESS		24a. REC'D BY REGISTRAR DATE 1-1-57	
				24b. REGISTRAR'S SIGNATURE <i>Willie H. Hays</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

1914

11988

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland, Md.		c. LENGTH OF STAY IN 1b 50yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 213 Hay St.		e. STREET ADDRESS 213 Hay St.	
3. NAME OF DECEASED (Type or print) Luigi Santoro		4. DATE OF DEATH Month 12- Day 30 Year 1956	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 21, 1877
9. AGE (In years last birthday) 79 yrs		IF UNDER 1 YEAR: Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tailor, Clothing Store		10b. KIND OF BUSINESS OR INDUSTRY Cerisano, Italy	
11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Raffaele Santoro		14. MOTHER'S MAIDEN NAME Carolina Pranno	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Mrs. Margaret D. Aman 213 Hay St.	
17. INFORMANT Mrs. Margaret D. Aman 213 Hay St.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Decompensation DUE TO Chronic Myocarditis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 19, 1956 to 31 Dec 1956 that I last saw the deceased alive on 31 Dec 1956 , and that death occurred at 6 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE F. B. Whitworth M.D. F. B. Whitworth PHYSICIAN'S NAME (Type) F. B. Whitworth			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF I-3-57	22c. NAME OF CEMETERY OR CREMATORY St. Patrick Cem	22d. LOCATION (City, town, or county) (State) Cumberland, Md.
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli		ADDRESS Cumberland, Md.	
24a. REC'D BY REGISTRAR Jan 13, 1957		24b. REGISTRAR'S SIGNATURE W. H. Harty M.D.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

WILLIAM A. L.

1957

1957

1

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11996

CERTIFICATE OF DEATH

11989

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>ALLEGANY</u>		STATE <u>PENNA</u> COUNTY <u>BEDFORD</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>HYNDMAN</u>		TOWN <u>HYNDMAN</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>CUMBERLAND</u>		LENGTH OF STAY (in this place) <u>2 MONTHS</u>		STREET ADDRESS (If rural give location)			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>324 BALTIMORE AVE</u>							
3. NAME OF DECEASED (Type or Print) <u>IOLA ELIZABETH SHAFFER</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>DEC 17 1956</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>		8. DATE OF BIRTH <u>Nov. 27, 1918</u>	
10a. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		9. AGE last birthday <u>38</u> yrs.		11. BIRTHPLACE (State or foreign country) <u>Hyndman, PA</u>	
13. FATHER'S NAME <u>HARRY E. Close</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>				16. SOCIAL SECURITY NO. <u>234-44-6762</u>		17. INFORMANT & ADDRESS <u>Raymond Shaffer, Hyndman PA</u>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>Carcinoma uterus</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u>			
ANTECEDENT CAUSE(S) DUE TO (B)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Dec 17</u> , 19 <u>55</u> , to <u>Dec 17</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Dec 17</u> , 19 <u>56</u> , and that death occurred at <u>5:00 P.M.</u> , from the causes and on the date stated above							
SIGNATURE <u>John C. Lopper</u> M.D.				ADDRESS (Street, city, town, state) <u>Hyndman PA</u> DATE SIGNED <u>12-18-56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>Dec 20, 1956</u>		NAME OF CEMETERY OR CREMATORY <u>Hyndman Cemetery</u>		LOCATION (City, town, or county) <u>Hyndman, PA</u>	
24. REC'D BY REGISTRAR <u>Dec 19, 1956</u>		REGISTRAR'S SIGNATURE <u>Walter R. Frantz, M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Harvey N. Lagler</u>		ADDRESS <u>Hyndman, PA</u>	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OF HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-5B 10M

BUREAU V. S.

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11997

11990

CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND, MD.				c. LENGTH OF STAY IN 1b 3 HRS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.,				d. STREET ADDRESS 6 BROWNING STREET		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First CATHERINE Middle V. Last SHANK				4. DATE OF DEATH Month DEC. Day 24 Year 1956			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH OCTOBER 8, 1917	
9. AGE (In years lost birthday) 39 yrs		10. IF UNDER 1 YEAR Months 48 Days 28 Hours 0 Min. 0		11. IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min. 0		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME MELVIN BERRYMAN				14. MOTHER'S MAIDEN NAME HELEN BREHM			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 214-07-6509		17. INFORMANT Memorial Hospital	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 201X DUE TO Prodigious Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 13 years DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH 13 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. 12 p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from 9-10- , 19 48 , to 12-24- , 19 56 , that I last saw the deceased alive on 12-24- , 19 56 , and that death occurred at 1:20P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Wm. F. Williams M.D.				ADDRESS (Street, city or town, state) Cumberland Md			
PHYSICIAN'S NAME (Type) WILLIAM F. WILLIAMS				DATE SIGNED 12/26/56			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 27, 1956		22c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		22d. LOCATION (City, town, or county) (State) Cumberland, Maryland.	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Maryland.				24. REC'D BY REGISTRAR Dec. 27, 1956		25. REGISTRAR'S SIGNATURE W.R. Frank, M.D.	

BUREAU V. 9

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DEC 3 1911

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 67 Marion St.		d. STREET ADDRESS 67 Marion St.	
3. NAME OF DECEASED (Type or print) First Katherine Middle Margaret Last Simmons		4. DATE OF DEATH Month Dec. Day 19 Year 19 56	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 26-1869
9. AGE (in years last birthday) 87 yrs.		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) Cumberland, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Anton Speis	
14. MOTHER'S MAIDEN NAME Mary Wheelan		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no	
16. SOCIAL SECURITY NO. none		17. INFORMANT Mrs. Floyd Simmons, Cumberland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Generalized arteriosclerosis 4-500 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH Gradual
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour _____ a. m. _____ p. m. _____ Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE H. V. Deming M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) H. V. Deming M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Dec. 22-1956	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Dec. 21-1956	22c. NAME OF CEMETERY OR CREMATORY St. Lukes Luthern Cemetery-Cumberland, Allegany, Md.	22d. LOCATION (City, town, or county) _____ (State) _____
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer		ADDRESS Cumberland, Md.	
24a. REC'D BY REGISTRAR Dec 22, 1956		24b. REGISTRAR'S SIGNATURE H. V. Deming, M.D.	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

U. S. DEPARTMENT OF AGRICULTURE

PLANT INDUSTRY

RESEARCH

11992 CERTIFICATE OF DEATH

11999

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1009 Penhurst Ave.,				d. STREET ADDRESS 1009 Penhurst Ave.,			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First LILLIE Middle ELIZABETH Last SMALL				4. DATE OF DEATH Month Dec. Day 24 Year 1956			
5 SEX Female		6 COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 12, 1889	
9 AGE (In years last birthday) 67 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		11 BIRTHPLACE (State or foreign country) Cumberland, Md.		12. CITIZEN OF WHAT COUNTRY? U. S.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own home		11 BIRTHPLACE (State or foreign country) Cumberland, Md.	
13. FATHER'S NAME George C. Wagner				14. MOTHER'S MAIDEN NAME Annie E. Vogtman			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No.				16. SOCIAL SECURITY NO. None		17. INFORMANT Mr. Charles W. Small Address Cumberland, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Cardiac Failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive Cardiovascular Disease DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH 5 hrs 10 yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Severe Kyphosis dorsal spine				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 8 Mar , 1954, to 24 Dec , 1956, that I last saw the deceased alive on 24 Dec , 1956, and that death occurred at 5:15 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 122 So. Centre St. DATE SIGNED 26 Dec 56							
ACTUAL SIGNATURE James G. Stegmaier M.D.				PHYSICIAN'S NAME (Type) James G. Stegmaier Cumberland, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/27/56		22c. NAME OF CEMETERY OR CREMATORY Millcrest Burial Park		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George Cumberland, Md.				24a. REC'D BY REGISTRAR Dec 27, 1956		24b. REGISTRAR'S SIGNATURE W.R. Frank, M.D.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

DEC 11 1951

11-11-51

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. LENGTH OF STAY IN 1b <u>1 day</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial Hospital</u>				d. STREET ADDRESS <u>1018 Gay St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>David</u> Middle <u>Leslie</u> Last <u>Smith</u>				4. DATE OF DEATH Month <u>Dec.</u> Day <u>28</u> Year <u>19 56</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 6-1956</u>		9. AGE (In years last birthday) <u>0</u> yrs.	IF UNDER 1 YEAR Months <u>2</u> Days	IF UNDER 24 HRS. Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>Cumberland, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Clarence A. Smith</u>				14. MOTHER'S MAIDEN NAME <u>Francenna Carder</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT Address <u>Father & Memorial Hospital records.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Lobar pneumonia (right)</u> (c) <u>Shock- 2nd. & 3 dr. degree burns right side of face</u>							INTERVAL BETWEEN ONSET AND DEATH <u>about 2 days.</u> <u>2 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>710. v</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part II at item 18.) <u>crib & set bed clothes afire. Lighted cigarette fell from mouth of mother in baby</u>					
20c. TIME OF INJURY Hour <u>4</u> a. m. <u>8</u> m. <u>Dec 27</u> 19 <u>56</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Cumberland, Allegany, Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and find that death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>H. V. Deming M.D.</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>H. V. Deming M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Dec. 28-1956</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>Dec. 28/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland, Allegany, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Louis Stein, Inc.</u>				ADDRESS <u>Cumberland, Md.</u>		24a. REC'D BY REGISTRAR <u>Dec. 28, 1956 W. R. Trantz M.D.</u>	
				24b. REGISTRAR'S SIGNATURE			

2060266XV5

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

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RECEIVED

DR. WEISMAN

11994

CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 5 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) MEMORIAL HOSPITAL				d. STREET ADDRESS RT. #5			
3. NAME OF DECEASED (Type or print) First HARRY Middle L. Last SMYTH				4. DATE OF DEATH Month DECEMBER Day 13 Year 19 56			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 19, 1899		9. AGE (In years last birthday) 57 yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MACHINIST		10b. KIND OF BUSINESS OR INDUSTRY B. & O. R.R.CO.		11. BIRTHPLACE (State or foreign country) PENNSYLVANIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME HARRY L. SMYTH James Smyth				14. MOTHER'S MAIDEN NAME Harriet Lafferty			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 705-05-4617		17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Embolus and Embolus DUE TO to left popliteal Artery Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) arterial thrombosis DUE TO Auricular Fibrillation (c) Probable myocardial Infarction							INTERVAL BETWEEN ONSET AND DEATH 5 days 5 days 5 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12/16 , 19 56 , to 12/13 , 19 56 , that I last saw the deceased alive on 12/12 , 19 56 , and that death occurred at 4:15 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Dr. Weisman M.D.				ADDRESS (Street, city or town, state) 59 GREENE ST CUMBERLAND, MD			
PHYSICIAN'S NAME (Type) DR. WEISMAN				DATE SIGNED 12/13/56			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 15, 1956		22c. NAME OF CEMETERY OR CREMATORY Millcrest Burial Park		22d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Md.				24a. REC'D BY REGISTRAR DATE 15/1956		24b. REGISTRAR'S SIGNATURE G. R. Lafferty, M.D.	

TO HOSPITAL OR PHYSICIAN: The form requires that the death certificate be executed within 48 hours after death. It may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

DEC 17 1900

BUREAU V. S.

11995 CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY ALLEGANY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND c. LENGTH OF STAY IN 1b 2 DAYS d. NAME OF HOSPITAL, CLINIC, OR INSTITUTION MEMORIAL HOSPITAL MEMORIAL AND WARWICK AVES.				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE WEST VIRGINIA b. COUNTY MINERAL c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ELK GARDEN d. STREET ADDRESS 828 - e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First GIP Middle C. Last SPERLING		4. DATE OF DEATH Month DECEMBER Day 29 Year 1956					
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APRIL 23, 1890	9. AGE (In years last birthday) 66 yrs.	IF UNDER 1 YEAR Months 1 Days 1 IF UNDER 24 HRS Hours 1 Min. 1		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Coal Miner		10b. KIND OF BUSINESS OR INDUSTRY Digging Coal		11. BIRTHPLACE (State or foreign country) ROMNEY, W. VA.			
12. CITIZEN OF WHAT COUNTRY? USA.		13. FATHER'S NAME JACK SPERLING		14. MOTHER'S MAIDEN NAME ELIZABETH DOMAN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 10		17. INFORMANT Address Memorial Hospital Cumberland Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of lung, right DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary Fibrosis, Emphysema, Myocardial Fibrosis					INTERVAL BETWEEN ONSET AND DEATH ?		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. s. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from 12-27-56 , 19____ to 12-29-56 , 19____, that I last saw the deceased alive on 12-29-56 , 19____, and that death occurred at 6:43A M, from the causes and on the date stated above ADDRESS (Street, city or town, state) 50 Pershing St., Cumberland, Md. DATE SIGNED 12-29-56							
ACTUAL SIGNATURE <i>Samuel E. Jacobson</i>		M.D. 50 Pershing St., Cumberland, Md.					
PHYSICIAN'S NAME (Type) SAMUEL E. JACOBSON							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Jan 1 1957	22c. NAME OF CEMETERY OR CREMATORY I.O.O.F. Cemetery	22d. LOCATION (City, town, or county)	(State)			
23. FUNERAL DIRECTOR'S SIGNATURE John P. Sharpless		ADDRESS Elk Garden, W. Va.		24a. REC'D BY REGISTRAR Dec 30, 1956	24b. REGISTRAR'S SIGNATURE <i>W.R. Frantz</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The funeral director, after this certificate has been signed by the attending physician and completely filled in, should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 should be retained by the registrar.

NOV 19 1964

RECEIVED

12030 CERTIFICATE OF DEATH

Reg. Dist. No.

-8

1 PLACE OF DEATH a. COUNTY Allegany MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lonaconing		c. LENGTH OF STAY IN 1b 72 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Detmold Street		d. STREET ADDRESS Detmold Street	
3 NAME OF DECEASED (Type or print) John M. Stafford		4. DATE OF DEATH Month 12/24/1956 Day 19	
5 SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 8/21/1884
9. AGE (In years last birthday) 72 yrs		IF UNDER 1 YEAR: Months 72 Days 72 Hours 72 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Coal Miner		10b. KIND OF BUSINESS OR INDUSTRY Lonaconing, MD.	
11. BIRTHPLACE (State or foreign country) U.S.A.		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME Alex Stafford		14. MOTHER'S MAIDEN NAME Margaret McKinnon	
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 217-09-8675	
17. INFORMANT Mrs. David McAninch, Lonaconing, MD		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 241X Congestive Heart Failure DUE TO (b) Chronic Bronchitis DUE TO (c) Chronic Bronchial Asthma		INTERVAL BETWEEN ONSET AND DEATH few months years years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour 19 o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec. 23, 1956 to Dec. 24, 1956 that I last saw the deceased alive on Dec. 23, 1956 , and that death occurred at P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Leslie R. Miles Jr.		DATE SIGNED 12.25.56	
PHYSICIAN'S NAME (Type) LESLIE R. MILES JR.		LONA CONING MD.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/27/1956	
22c. NAME OF CEMETERY OR CREMATORY Laurel Hill Cemetery		22d. LOCATION (City, town, or county) (State) Moscow, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE GEORGE EICHORN		ADDRESS LONA CONING, MD.	
24a. REC'D BY REGISTRAR 12/27/56		24b. REGISTRAR'S SIGNATURE Jannette M. Pool	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use of the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

12/1/19

11996 CERTIFICATE OF DEATH

Reg. Dist. No. 4

1 PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 12 HOURS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SACRED HEART HOSPITAL		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL LAVALE	
		d. STREET ADDRESS L	
3 NAME OF DECEASED (Type or print) TROXELL First Middle Last		4. DATE OF DEATH DECEMBER 26 Month Day Year 56	
5 SEX MALE	6 COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/14/04
9 AGE (In years last birthday) 52 yrs		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver		10b. KIND OF BUSINESS OR INDUSTRY Brewery	11. BIRTHPLACE (State or foreign country) Westernport, Md.
12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME William Stealey		14. MOTHER'S MAIDEN NAME Katherine Lambert	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 214-05-4777	
		17. INFORMANT Address Mary B. Stealey, Rt. 1, Cumberland, Md.	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage from esophageal varices 581.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hepatic cirrhosis DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 48 hrs 2 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 12-25-56 , 19 to 12-26- , 1956, that I last saw the deceased alive on 12-26-56 , 19, and that death occurred at 5 A. M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE C. C. Zimmerman		ADDRESS (Street, city or town, state) Cumberland, Md. DATE SIGNED 12-26-56	
PHYSICIAN'S NAME (Type) C. C. ZIMMERMANN			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12/28/1956	22c. NAME OF CEMETERY OR CREMATORY Philos Cemetery	22d. LOCATION (City, town, or county) (State) Westernport, Md.
23 FUNERAL DIRECTOR'S SIGNATURE William H. Kight, Cumberland, Md.		24a. REC'D BY REGISTRAR 12-28-1956 24b. REGISTRAR'S SIGNATURE W. R. Hantz, Md.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. 2. 3. 4. 5. 6. 7. 8. 9. 10.

1. 2. 3. 4. 5. 6. 7. 8. 9. 10.

12031 CERTIFICATE OF DEATH

Reg. Dist. No.

10

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Savage				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Savage			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First ELLEN Middle ANGELA Last STEPHENS				4. DATE OF DEATH Month Dec. Day 19 Year 19 56			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-4-1896	9. AGE (In years last birthday) 60 yrs.	IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS. Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) clerk		10b. KIND OF BUSINESS OR INDUSTRY Confectionery store		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Stephens				14. MOTHER'S MAIDEN NAME Catherine Malloy			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 215-10-2286		17. INFORMANT Thos. Stephens, Mt. Savage, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Hemorrhage from stomach DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma of liver (primary) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 1 mo 7 mo	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. — p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May , 19 56 , to Dec 19 , 19 56 , that I last saw the deceased alive on Dec 19 , 19 56 , and that death occurred at 9 P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Lysle R. Everhart M.D.				ADDRESS (Street, city or town, state) Rt 1 Box 39 Cumberland Md			
PHYSICIAN'S NAME (Type) Lysle R. Everhart M.D.				DATE SIGNED 12/21/56			
22a. BURIAL CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-22-56		22c. NAME OF CEMETERY OR CREMATORY St. Patrick's Cem.		22d. LOCATION (City, town, or county) (State) Mt. Savage, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. R. Durst,				ADDRESS Frostburg, Md.		24a. REC'D BY REGISTRAR DATE 12-21-56	
				24b. REGISTRAR'S SIGNATURE Veronica M. Durrmitt			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in on page 3 show, it be detached for use as the burial-transit permit. Then please remove coroner papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

OF

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1 Filed 12-27-56 et

12020

CERTIFICATE OF DEATH

12006

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg				c. LENGTH OF STAY IN 1b 25 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION At home				d. STREET ADDRESS 156 Maple St.			
3. NAME OF DECEASED (Type or print) First Henry Middle H. Last Taylor				4. DATE OF DEATH Month December Day 14th Year 1956			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 4th, 1882		9. AGE (In years last birthday) 74 yrs	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Coal Miner		10b. KIND OF BUSINESS OR INDUSTRY Coal Mining		11. BIRTHPLACE (State or foreign country) Broadford, Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Harry Taylor				14. MOTHER'S MAIDEN NAME Dorothy Lumson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unk.		16. SOCIAL SECURITY NO. 213-09-6609		17. INFORMANT Mrs. Minnie S. Taylor, Frostburg, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMATOSIS 151X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CARCINOMA Pyloric Stomach DUE TO (c) 2 1/2 yrs						INTERVAL BETWEEN ONSET AND DEATH 2 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Uremia						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTR BUT NG <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that I attended the deceased from OCT , 1953, to Dec 14 , 1956, that I last saw the deceased alive on Dec 14 , 1956, and that death occurred at M , from the causes and on the date stated above.							
ACTUAL SIGNATURE John C. Durst M.D.				ADDRESS (Street, city or town, state) 134 E Main DATE SIGNED 12/17/56			
PHYSICIAN'S NAME (Type) John C. Durst				Frostburg, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-18-56		22c. NAME OF CEMETERY OR CREMATORY F'bg. Memorial Park		22d. LOCATION (City, town, or county) (State) Frostburg, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph R. Durst,				ADDRESS Frostburg, Md.		24a. REC'D BY REGISTRAR DATE 12-18-56	
				24b. REGISTRAR'S SIGNATURE Mrs. Nancy H. Doe			

BUREAU V. 2

1956

RECEIVED

11997 CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. LENGTH OF STAY IN 1b <u>60 years</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>308 Williams Street</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>	
f. STREET ADDRESS <u>308 Williams Street</u>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>OLIVER</u> Middle <u>TWIGG</u> Last <u>TWIGG</u>		4. DATE OF DEATH Month <u>Dec.</u> Day <u>17</u> Year <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>WIDOWED</u> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 11, 1863</u>
9. AGE (In years last birthday) <u>93 yrs.</u>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Contractor - Retired</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>John Twigg</u>		14. MOTHER'S MAIDEN NAME <u>Jane Newell</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Marshall C. Twigg, Cumberland, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic myocarditis</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Senility</u>			
INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u> <u>4 years</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. g. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec 15</u> , 19 <u>56</u> to <u>Dec 17</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Dec 17</u> , 19 <u>56</u> , and that death occurred at <u>8-55 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W. J. Truaskis Jr</u>		ADDRESS (Street, city or town, state) <u>Cumberland, Maryland</u>	
DATE SIGNED <u>12/18/56</u>			
PHYSICIAN'S NAME (Type) <u>A. W. T. PEVA & NIS, Jr</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12-20-1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Herman Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Cumberland, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>William H. Kight, Cumberland, Md.</u>		24. REC'D BY REGISTRAR <u>Dec 19, 1956</u>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <u>W. H. Kight, Md.</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

1956

RECEIVED

11998

CERTIFICATE OF DEATH

Reg. Dist. No.

4

1 PLACE OF DEATH a. COUNTY (Md.) Allegany MARYLAND			2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Allegany		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 8/15/56		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary			d. STREET ADDRESS 77 Broadway		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3 NAME OF DECEASED (Type or print) First Annie Middle L. Last Willison			4. DATE OF DEATH Month December Day 25, Year 19 56		
5 SEX Female	6. COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 2/6/1873		9. AGE (In years last birthday) 83 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11 BIRTHPLACE (State or foreign country) Frostburg, Maryland	
13. FATHER'S NAME Andrew J. Willison			14 MOTHER'S MAIDEN NAME Missouri Hartzell		
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16 SOCIAL SECURITY NO (If yes, give war or dates of service) None		17 INFORMANT P/O. Box 599 Address Cumberland, Md. Allegany County Infirmary records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic myocarditis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coroner's arteriosclerosis DUE TO (c) Chronic nephritis					INTERVAL BETWEEN ONSET AND DEATH ? ? ?
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Severe psychosis					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8/15/56, 19, to 12/25/56, 19, that I last saw the deceased alive on 12/25/56, 19, and that death occurred at 10:25 PM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 49 Greene St. 12/26/56					
ACTUAL SIGNATURE James E. McLean		M.D. 49 Greene St. 12/26/56			
PHYSICIAN'S NAME (Type) James E. McLean		Cumberland, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 28, 1956		22c. NAME OF CEMETERY OR CREMATORY Frostburg Memorial Park	
				22d. LOCATION (City, town, or county) (State) Frostburg, Maryland.	
23. FUNERAL DIRECTOR'S SIGNATURE J. R. Durst, Frostburg, Maryland.			24a. REC'D BY REGISTRAR Dec. 27, 1956		24b. REGISTRAR'S SIGNATURE W. R. Hantz, M.D.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. E.

DEC 31 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12009

11999

CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN TB 12 1/2 HRS.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ELEANOR Middle M Last NEFF WILSON				4. DATE OF DEATH Month DECEMBER Day 12 Year 1956			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JAN. 15, 1895	
9. AGE (In years last birthday) 61 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Employee-Veteran's Adm.-U.S. Gov't. Retired		11. BIRTHPLACE (State or foreign country) Frostburg, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME HENRY NEFF				14. MOTHER'S MAIDEN NAME ELLA GUNNETT			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Memorial Hospital			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH 8 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. ft. p. m. _____ 19____		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7/6/56 , 19____, to 12/12/56 , 19____, that I last saw the deceased alive on 12/12/56 , and that death occurred at 9:45 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE RICHARD J. WILLIAMS M.D.				ADDRESS (Street, city or town, state) Cumbersburg			
PHYSICIAN'S NAME (Type) RICHARD J. WILLIAMS				DATE SIGNED 12/12/56			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 14, 1956		22c. NAME OF CEMETERY OR CREMATORY Frostburg Memorial Park		22d. LOCATION (City, town, or county) (State) Frostburg, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Hafer Funeral Home, Frostburg, Maryland.				24a. REC'D BY REGISTRAR Dec. 12, 1956		24b. REGISTRAR'S SIGNATURE Winter R. Frank, Jr.	

BUREAU Y. S.

DEC 14 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 and 5 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH--BALTIMORE, 18

12010

CERTIFICATE OF DEATH

Reg. Dist. No. 4

12000

1 PLACE OF DEATH a COUNTY <u>Allegheny</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a STATE <u>Penn.</u> b COUNTY <u>Bedford</u>			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>				c LENGTH OF STAY IN 1b <u>DOA</u>			
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Sacred Heart Hospital</u>				e STREET ADDRESS <u>Rt. 3, Bedford Road</u>			
3 NAME OF DECEASED (Type or print) First <u>Alice</u> Middle <u>Pearl</u> Last <u>Zentow</u>				4 DATE OF DEATH Month <u>December</u> Day <u>23</u> Year <u>1956</u>			
5 SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 12, 1885</u>	
9 AGE (in years last birthday) <u>71</u> yrs		10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Bedford Valley, Penn.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Samuel Wentling</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Sarah Burner</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)	
16 SOCIAL SECURITY NO. <u>None</u>		17 INFORMANT <u>Daughter Mrs. Wilda Daab, 445 Goethe St. City</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> 420.1 DUE TO <u>Embolic Atrial Fibrillation</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Atrial Fibrillation</u> (c) <u>None</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 <u>56</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from <u>Jan. 29, 1956</u> to <u>Dec. 29, 1956</u> that I last saw the deceased alive on <u>Dec. 29, 1956</u> , and that death occurred at <u>7:00 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>B. M. Schindler, M.D.</u>				ADDRESS (Street, city or town, state) <u>445 Goethe St., City</u>			
PHYSICIAN'S NAME (Type) <u>B. M. Schindler, M.D.</u>				DATE SIGNED <u>Jan. 30, 1956</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/31/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>P.O.S. of A. Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Centerville, Pennsylvania</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John</u> ADDRESS <u>250 Baltimore Avenue, Cumberland, Maryland</u>				24a. REC'D BY REGISTRAR <u>Jan. 30, 1956</u>		24b. REGISTRAR'S SIGNATURE <u>W.R. Frantz, M.D.</u>	

BUREAU A. S.

NO. 100

RECEIVED
JAN 10 1900

Outside of City limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12011

12001

CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland				c. LENGTH OF STAY IN 1b Two Weeks			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Residence Rt. 3, Bedford Road				d. STREET ADDRESS Route 3, Bedford Road			
3. NAME OF DECEASED (Type or print) First Carrie Middle Ethel Last Zembower				4. DATE OF DEATH Month December Day 4 Year 1956			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec 23 1877	
9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR Months 4 Days 15 Hours 56 Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House		10b. KIND OF BUSINESS OR INDUSTRY House Wife	
11. BIRTHPLACE (State or foreign country) Bedford Valley, Pa.				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Henry Hite				14. MOTHER'S MAIDEN NAME Margaret Deffibaugh			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs Wilbur Hardinger Rt 3, Cumberland, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident 331x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Essential hypertension DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 14 HOURS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Thyroid goiter, generalized arteriosclerosis						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Centerville, Pa.				(County) (State)			
21. I certify that I attended the deceased from November 24 1956 , to December 4, 1956 , that I last saw the deceased alive on December 4, 1956 , and that death occurred at 9:00 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Max A. Stoner				ADDRESS (Street, city or town, state) R.F.D. #3, Bedford, Pennsylvania			
PHYSICIAN'S NAME (Type) MAX A. STONER				DATE SIGNED 12/4/56			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec 7 1956		22c. NAME OF CEMETERY OR CREMATORY Bethel Cemetery		22d. LOCATION (City, town, or county) (State) Centerville, Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE William A. Hite				24a. REC'D BY REGISTRAR Dec 6, 1956			
ADDRESS Cumberland, Md.				24b. REGISTRAR'S SIGNATURE W.R. Frantz, M.D.			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

9907

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12012

12002

CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LaVale			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sacred Heart Hospital				d. STREET ADDRESS 10 B Street			
3. NAME OF DECEASED (Type or print) First Harvey Middle Ross Last Zembower				4. DATE OF DEATH Month 12/16/56 Day 19 Year 19			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/31/1884	9. AGE (In years last birthday) 72 yrs.	IF UNDER 1 YEAR Months 12 Days 16 Hours 56 Min.	IF UNDER 24 HRS. Months 12 Days 16 Hours 56 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Merchant			10b. KIND OF BUSINESS OR INDUSTRY Feed Business		11. BIRTHPLACE (State or foreign country) Pa. Bedford Valley		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME William P. Zembower				14. MOTHER'S MAIDEN NAME Vergie Ressler			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 217-10-6745		17. INFORMANT Patient's Chart			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cerebral hemorrhage 331X DUE TO cerebral arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) cerebral arteriosclerosis DUE TO (c) cerebral arteriosclerosis							INTERVAL BETWEEN ONSET AND DEATH 5 days years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) pulmonary emphysema, par pulmonary							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 12/15 to 12/16 , 19 56 , that I last saw the deceased alive on 12/15 , 19 56 , and that death occurred at 4:05 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Elizabeth Briggs			ADDRESS (Street, city or town, state) 55 Greene St. Cumberland Md				
PHYSICIAN'S NAME (Type) E. G. BRINGS M.D.			DATE SIGNED 12/16/56				
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 12/19/56		22c. NAME OF CEMETERY OR CREMATORY Willcrest Burial Park		22d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland				24a. REC'D BY REGISTRAR DATE 21, 1956		24b. REGISTRAR'S SIGNATURE W.R. Frantz, M.D.	

RECEIVED

DEC 2 1944

BUREAU V. S.